140 S Beach Suite 310, Daytona Beach FL 32114
Email: assistant@thehopegroup4.com P.386.898.6040 F.386.256.2320

Today's Date: _____

Patient Information

Last Name: _____

First Name: _____

Date of Birth: _____ Age: _____

Developmental Age: _____ Sex: _____

Address: _____

_____

Preferred Phone Number: _____

Caregiver Email: _____

Insurance Information

Please provide a copy of your insurance card to your therapist during the first visit

Primary Health Insurance: _____ Member ID: _____

Name of Subscriber: _____ Birthday of Subscriber: _____

Address of Subscriber: _____

_____

Secondary Health Insurance: _____ Member ID: _____

Name of Subscriber: _____ Birthday of Subscriber: _____

In Case of Emergency

Name of Emergency Contact: _____ Relationship to Patient: _____

Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hope Harbor Therapies or insurance company to release any information required to process my claims.

Signature: _____ Relationship to Patient: _____