CLIENT INSURANCE REGISTRATION

CLIENT NAME: _____

DATE OF BIRTH: _____

PAYMENT INFORMATION: Person Responsible for the bill:

_____

Address: _____

City: _____ State:_____ Zip Code:_____

Phone: Home: _____ Work: _____ Cell:

_____

Is this client covered by insurance? _____ Yes _____ No

Name of Insurance Carrier or Therapy Coverage:

_____

Plan ID # _____ Group # _____

Subscriber's Name: _____

Client's Relationship to Subscriber: ____ Self ____Spouse ____ Child ____Other

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

_____ _____

Client Signature Date