Southfield Therapy – New Patient Information

Patient Information (If Different from Guarantor)

Patient Name:_____

Patient Address:_____
(Address) (City) (State) (Zip)

Home Phone:_____ Gender:_____

Student: FT ☐ PT ☐ N/A ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Other ☐

Work Status: FT ☐ PT ☐ Self-Emp. ☐ Not Employed ☐ Retired (Date:_____)

Patient Employer:_____

Work Address:_____
(Address) (City) (State) (Zip)

Work Phone:_____ SSN: _____

Date of Birth: _____ Relationship to Guarantor:_____

Guarantor Information (Financially Responsible Person)

Guarantor Name:_____ Date of Birth: _____

Guarantor Address:_____
(Address) (City) (State) (Zip)

Home Phone:_____ Gender:_____

Student: FT ☐ PT ☐ N/A ☐ Marital Status: S ☐ M ☐ D ☐ W ☐ Other ☐

Work Status: FT ☐ PT ☐ Self-Employed ☐ Not Employed ☐ Retired (Date:_____)

Guarantor Employer:_____

Work Address:_____
(Address) (City) (State) (Zip)

Work Phone:_____ SSN: _____

Referring/Ordering Physician

Referring/Ordering Physician (full name if possible):_____

Referring/Ordering Physician Number (if applicable): _____

Southfield Therapy – New Patient Information Cont.

Primary Insurance Information (Copy Front and Back of Card & Attach)

Primary Insurance Company Name:_____

Company Address:_____
(Address) (City) (State) (Zip)

Phone:_____ Policy Number:_____

Group Number: _____ Plan Name:_____

Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐

If not Self, Policy Holder's Name: _____ Date of Birth: _____

Secondary Insurance Information (Copy Front and Back of Card & Attach)

Secondary Insurance Company Name:_____

Company Address:_____
(Address) (City) (State) (Zip)

Phone:_____ Policy Number:_____

Group Number: _____ Plan Name:_____

Policy Holder: Self ☐ Spouse ☐ Child ☐ Other ☐

If not Self, Policy Holder's Name: _____ Date of Birth: _____

Authorization

I certify that the information as given on this form is correct and complete to the best of my knowledge.

I hereby authorize the release of any media and/or other information to be shared with all health care providers involved in my care.

I authorize the release of any medical or other information necessary to process this claim and/or any payments.

I assign, transfer, and set over all of my rights, title, and interest of my medical reimbursement benefits under my insurance policy/policies for services rendered to Change is Coming.

I further agree to pay for any and all services not paid by my insurance benefit plan(s).

In the event that my health insurance plan falls under the jurisdiction of ERISA law, designate Change is Coming as my authorized representative to act on the claimant's behalf for all claims assigned to the provider of services.

Signed:_____ Date: _____

PLEASE MAKE SURE THAT FRONT AND BACK COPIES OF INSURANCE CARD(S) ARE PROVIDED WITH THIS DOCUMENT