Sprouts Therapy
Client Intake Form

General Information:

Client Name:_____Date of Birth:_____

Your Name & Relationship to Client:_____

Address_____Phone #:_____

Insurance & Sponsor Information:

Insurance Name:_____Sponsor:_____

Date of Birth:_____SSN #:_____

Relationship to Client:_____ID #:_____

Employer:_____Position/Title:_____

Physician:_____Phone #:_____

Please be sure to provide a copy of your Insurance ID Card and a MD prescription for services

I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all the services rendered to me by Sprouts Therapy and its practitioners. I also understand that all out-of-network (non-contracted) insurance billing services provided by Sprouts Therapy on my behalf are performed on a courtesy basis and can be discontinued by either myself or Sprouts Therapy with written notice at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to the providers(s) at Sprouts Therapy. I understand my co-pay is due at the time of services rendered. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature_____

Print Name_____Date:_____

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