Back to the Garden Counseling Services

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Patient Information Sheet

PATIENT INFORMATION

Name: _____ Male / Female

Address: _____

Street City State Zip

Home Phone _____Work Phone_____

Cell Phone_____Employeer_____

Birthdate _____ Age _____ SS#_____ Married Single Other

BILLING INFORMATION

Responsible Party _____ Relationship to Client: Self Spouse Child Other

Address: _____

Street City State Zip

Home Phone_____ Work Phone #: _____

Birthdate _____Age_____ SS# _____Married Single Other

INSURANCE COMPANY _____

Subscriber ID (or Claim #)_____ Group _____

Claims Phone Number _____

Primary Care Physician _____

Phone _____Fax_____

Diagnosis ***(for provider use only)***_____

I state that I have insurance as noted above and assign all benefits payable directly to Gary L. Garvin M. Ed., L.M.H.C. I understand that my insurance company is billed as a courtesy to me and agree by signing below to pay the charges in full In the event of non-payment by my insurance company within 60 days of billing. I understand that it is my responsibility to meet any referral requirements of my insurance plan and that I will be responsible for payment if claims are denied due to violation of referral policy. I authorize Gary L. Garvin M. Ed., L.M.H.C. to release all information necessary (including Chart notes) to my insurance company to secure payment of benefits.

_____ _____

Signature Date