Insurance Information

Patient Name	Birth date	DDD Assist # (If applicable)	Sex	SS#
Address	City		State	Zip code
Home Phone	Diagnoses			
Father	Work Phone	Mother		Work Phone
Referred by (Physician name or DDD Case Manager)			DDD Case Manager	
Primary Physician				Phone

Private Insurance Plan (if applicable)

Employer			
Policy Holder	SS#		Birth date
Address (*if different from patient*)	City	State	Zip code
Group #	ID or Policy #		
Send Claims to:			Phone
Address	City	State	Zip code

State Coverage (AHCCCS plans)

Employer			
Policy Holder	SS#		Birth date
Group #	ID or Policy #		
Send Claims to:	Phone		
Address	City	State	Zip code

MEDICAL INFORMATION RELEASE

I hereby authorize the release of any information, including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies or other health care agencies. I also authorize the release of medical records or copies of such and request that they be transferred to Therapy Matters, Inc. 2200 E. Williams Field Rd. Suite 200 Gilbert, Az. 85295

FINANCIAL POLICY

I understand and agree that I am ultimately responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience. I understand and agree that if it becomes necessary to retain an attorney and/or collection agency for the collection of any outstanding charges, whether or not a lawsuit is filed on my account, I will be responsible for any attorney and/or collection fees and court costs in addition to the outstanding balance, Patients authorized for therapy by the Arizona Department of Economic Security, Division of Developmental Disabilities, are not responsible for payment of charges.

CANCELLATION POLICY

If you need to cancel an appointment, we request a 24-hour notice. If you cancel within less than 24 hours of your scheduled appointment, you may be charged for 1/2 of the scheduled session. If you do not call to cancel and fail to keep your appointment, you will be charged for 1/2 of the scheduled session. Insurance will not pay for such "no shows" or late cancellation charges-these charges must be paid by the patient. If you have 2 or more cancellations within a 4-week period, or 2 or more no shows, we reserve the right to discontinue services.

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits be made on my behalf to Therapy Matters, Inc.

Signature:_____ Date:_____