The Oates Group, PLLC

Client Information

Client Name:_____

Street Address:_____

City:_____State_____Zipcode_____

Home Phone:_____Cell Phone:_____

E-mail Address:_____

Employer:_____Referred By:_____

Person Responsible for Bill (If different from above)

Name:_____

Address:_____Phone:_____

City:_____State:_____Zipcode:_____

Authorization to pay benefits to Practitioner and to Release Information: I hereby authorize The Oates Group, PLLC to release any information during the course of my evaluation necessary to process insurance claims and to submit claims for and receive any benefits for which I (or the patient) may be eligible, for services rendered by the practitioner, realizing I am responsible to pay non-covered services.

SIGNATURE **DATE**

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