Lifting Spirits Therapy Services, Inc.

Patient Information Form

Patient Information

Patient Name ______________________ Date of Birth ______________________

Street Address ____

City ______________________ State __________ Zip ______________________

Insurance Carrier

❑ ❑	Medicaid Peach State	❑ ❑	Peach Care Amerigroup	❑ ❑	Private Insurance Well Care

Medicaid Number ______________________________________

Parents Information

Mother's Name ______________________ Father's Name ______________________

Mother's Number ______________________ Father's Number ______________________

Pediatricians Information

Pediatricians Name ______________________________________

Address ______________________________________

City ______________________ State __________ Zip ______________________

Phone ______________________ Fax ______________________

I authorize Payment of medical benefits to undersigned physician or supplier for service described above.

Signature ______________________________________ Date ______________________