

Personal Information Form

Patient Name: _____ **DOB:** _____

Address: _____

Phone: (home) _____ **Primary Care Physician:** _____
(cell) _____
(work) _____

SSN: _____

Referred by: _____

Email address: _____

For patients younger than 18 years of age, please complete the following:

Father: _____

Address: _____

Phone: (home) _____

(cell) _____

(work) _____

Email address: _____

Mother: _____

Address: _____

Phone: (home) _____

(cell) _____

(work) _____

Email address: _____

Financial Agreement

I understand that payment is expected at the time of service. A fee of \$35 will be assessed for any returned checks. I understand that I may be responsible for full payment if I do not give 24-48 hours notice of cancellation or change of appointment. I understand that my insurance company will not be responsible for this payment. I also understand that failure to maintain responsibility for payment over the long term may result in my account being sent to an independent agency for collection. I consent to the release of information for this purpose, and I agree to pay any costs associated with such collection. I authorize Arizona TherapyWorks and Dr. Barbara Baumgardner to release any medical or mental health information necessary to help me process insurance claims.

Patient/Parent/Guardian

Date