Amethyst
Center for Healing

Client Information

Client Name:_____

Address:_____Apt #:_____

City:_____**State**:_____**Zip**:_____

Client's Date of Birth: _____ Age:_____ Gender: _____

Home Phone: _(_____)_____**Cell Phone**:_(_____)_____

Email address: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Child ☐ Other:_____

Primary Insurance Co. Name:_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

Insurance ID#:_____**Group #**:_____

Subscriber's Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Co.Name:_____

Insurance Co. (800) Number:_____

Name of Insured (Subscriber):_____Date of Birth:_____

Insurance ID#:_____**Group #**:_____

Subscriber's Employer:_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

I authorize provider to release information to insurance carrier(s) listed, or the billing clearinghouse used by this provider, and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.

If it becomes necessary to effect collections of any amount owned, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature: _____Date:_____