



Patient Name (First, MI, Last)		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone
Present Address			City	State Zip
Cell Phone		Social Security #	E-mail Address	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed				
Date of Occurrence	Cause of Injury: <input type="checkbox"/> Auto Accident <input type="checkbox"/> Workers' Comp	Doctor's Diagnosis		Referring Physician
Primary Insurance		Subscriber # or ID #		Group or Plan #
Secondary Insurance		Subscriber # or ID #		Group or Plan #
(For Office Use Only) Verify Insurance Coverage				Initials

IF INJURED IN AN AUTO ACCIDENT PLEASE FILL OUT BOX BELOW

Auto Insurance being billed	Claim #	Adjuster or Agent Name	Phone #
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IF INJURED IN WORK RELATED ACCIDENT PLEASE FILL OUT BOX BELOW

Employer or Insurance Company	Claim #	Adjuster or Employer Contact	Phone #
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I hereby authorize Agape Therapy to furnish any information to any and all insurance carriers concerning me or my dependents. I also hereby assign to Agape Therapy all payments for services rendered to me or my dependents. I understand that I am solely responsible for any charges incurred that are not subsequently covered by my insurance.

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have received a copy of Agape Therapy's Notice of Privacy Practices.

Signature Date

*If you signed as the **patient's representative**, please print your name and describe your relationship to the patient below.

Name Relationship to Patient

CANCELLATION/NO SHOW POLICY: There will be a \$25 fee charged to any patient who doesn't keep an appointment as scheduled, or fails to notify us of a cancellation **prior to 5:00 p.m.** the previous business day.

Signature: _____ Date _____