



Fairplay Therapy Center

PATIENT INFORMATION

Name Last _____ First _____ MI _____ Date _____
 Date of Birth ____ / ____ / ____ Social Sec. ____ - ____ - ____ Drivers License# _____
 Mailing Address _____ City _____ State _____ Zip _____
 Physical Address _____ City _____ State _____ Zip _____
 Phone Numbers _____
 Email Addy (optional) _____
 Employer _____ Ph: _____ Occupation _____
 Employer Address _____ City _____ State _____ Zip _____
 Emergency Contact Person _____ Ph: _____

GENERAL INFORMATION

Referring Doctor _____ Ph: _____
 Primary Doctor _____ Ph: _____
 Was there an Accident? Y / N Auto _____ Work _____ Other _____ Was there a Surgery? Y / N
 Description of Problem _____
 How long? _____ Have you had this or similar issues before? _____
 What aggravates your condition? _____
 What improves your condition? _____
 Is this condition becoming progressively worse? (circle) Yes No Constant Comes & goes
 This condition interferes with: (circle all that apply) Work Sleep Daily routine Other _____
 List previous diagnoses/treatments you have received for this condition _____

INSURANCE INFORMATION

Policy Holders Name (if other than the Patient) _____
 Insurance Company _____ Insurance Phone _____
 ID# _____ Group# _____ Is there Secondary Insurance? Y / N
We will need a copy of your insurance card(s)

Notice of Privacy Practices/Medical Release of Information

I authorize the release of any medical information necessary to process this claim. I acknowledge that I have received a copy of the privacy practices.
 Printed Name _____ Signature _____ Date _____

ASSIGNMENT OF BENEFITS AND CONSENT FOR TREATMENT

I hereby assign payment directly to Sacred Living Inc. dba Fairplay Therapy Center. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered. I hereby give my consent to Fairplay Therapy Center, to provide services to myself and/or family.

Printed Name _____ Signature _____ Date _____

I understand insurance co-pays are expected at time of service. (Please Initial) _____

Missed Appointments: Unless cancelled at least 24 hours in advance, we may charge for missed appointments. Please help us serve you better by keeping scheduled appointments. (Please Initial) _____