
# Patient Information

**Patient Name (First, MI, Last)_____Date of Birth ____ /____ /____ M ☐ F ☐**

Address _____ City, State, ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Emergency Contact Name/Number_____

Parent/Guardian Name (if patient is a minor) _____

## Insurance Information

Primary Insurance _____

Insurance ID # _____ Group# _____

Patient's relationship to insured (Circle one): Self Spouse Child Other: _____

Policyholder Name _____ DOB _____ Employer _____

Policyholder Address _____

(If different from patient's address)

Secondary Insurance _____

Member# _____ Group# _____

Policyholder Name _____ DOB _____ Employer _____

Policyholder Address _____

(If different from patient's address)

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist/counselor to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though I had personally signed the particular claim.

I hereby authorize my insurance company (_____) to pay and hereby assign directly to TEAM Restoration Ministries all benefits, if any, otherwise payable to me for his/her services received by a TEAM Restoration therapist. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to TEAM Restoration Ministries, will be credited to my account, in accordance with the above said assignment.

_____ _____

Signature Date