

# CONTINUUM WELLNESS CLINIC

## PATIENT INFORMATION \*PLEASE PRINT\*

Patient Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ SS#: \_\_\_\_\_  
Patient Birthdate: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Minor \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_  
Patient Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
If patient is a student, name of school/college: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
Person to contact in an emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring physician \_\_\_\_\_ /ph# \_\_\_\_\_  
Primary care physician \_\_\_\_\_ /ph# \_\_\_\_\_  
Date of injury/surgery \_\_\_\_\_ Car accident? \_\_\_\_\_ Driver \_\_\_\_\_ Passenger \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION \* PLEASE PRINT\*

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ PO Box \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer address \_\_\_\_\_ Phone \_\_\_\_\_  
Friend or relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION \*PLEASE PRINT\*

### PRIMARY INSURANCE

Policyholder name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Ins ID# \_\_\_\_\_ SS# \_\_\_\_\_ GROUP # \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Employer \_\_\_\_\_

### SECONDARY INSURANCE

Policyholder name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Ins ID# \_\_\_\_\_ SS# \_\_\_\_\_ GROUP # \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Employer \_\_\_\_\_

## SIGNATURE ON FILE/FINANCIAL AGREEMENT

I hereby authorize the treating Therapist and/or Continuum Wellness Clinic to release any information acquired in the course of my examination and/or treatment to my referring physician or insurance carrier(s) listed above. I hereby authorize Continuum Wellness Clinic to obtain, in my behalf, any information covered by the "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to Continuum Wellness Clinic and/or it's representatives for medical benefits. The financial policy of Continuum Wellness Clinic has been fully explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I also understand that there will be a \$25 fee for any appointments that I fail to keep and that I do not call and cancel. I agree to pay this fee immediately upon receipt. I further agree to pay all finance charges, collection costs, attorney fees or other outstanding costs that may be incurred to enforce collection of outstanding amounts due.

PATIENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_