Patient Billing Information Form

Patient's Full Name: ________________________ Date of Birth: _______________

Gender: ___Male ___ Female ___ Other

Address: ______________________________________

City: _________________________________ State:_________ Zip:________

Cell Phone: ______________________ Home Phone: _____________________

E-Mail:

Responsible Party Information (If different than above):

Full Name: _______________________________ Date of Birth: _____________________

Relationship to Patient:

Address: ______________________________________

City: _________________________________ State:_________ Zip:________

Cell Phone: ______________________ Home Phone: _____________________

E-Mail:

I agree to take full financial responsibility for the services offered by the therapist.

Patient's Signature: __________________________________ Date: _______________

Print Name: ________________________________