Date: _____ file #: _____

Dx: _____

Patient Information:

Patient Name: _____ MI: ____ Last Name: _____ S.S.#: _____

Address: _____ City:_____ ST: _____ Zip: _____

Home Phone: ( )_____-_____ Birthdate: _____/_____/_____ Sex: M F Marital Status : S M D W

Employer: _____ Address: _____ City:_____ ST: _____ Zip: _____

Work Status: Full Time Part Time Retired Student School: _____ Full Time Part Time

Guarantor Information (Responsible Party):

Patient Name: _____ MI: ____ Last Name: _____ S.S.#: _____

Address: _____ City:_____ ST: _____ Zip: _____

Home Phone: ( )_____-_____ Birthdate: _____/_____/_____ Sex: M F Marital Status : S M D W

Employer: _____ Address: _____ City:_____ ST: _____ Zip: _____

Work Status: Full Time Part Time Retired Student School: _____ Full Time Part Time

Payment & Insurance Information (we will need a copy of your insurance card):

Primary Insurance: _____ Address: _____ City:_____ ST: _____ Zip: _____

Phone: ( )_____-_____ Type: ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name: _____ Group Plan #: _____ ID.#: _____

Policy Holder: _____ Birthdate: _____/_____/_____ Relation to Patient: Self Spouse Parent Other

Other Insurance: _____ Address: _____ City:_____ ST: _____ Zip: _____

Phone: ( )_____-_____ Type: ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name: _____ Group Plan #: _____ ID.#: _____

Policy Holder: _____ Birthdate: _____/_____/_____ Relation to Patient: Self Spouse Parent Other

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that Thorn/Jetson Corporation doing business as Jetson Counseling or Thorn Counseling will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Jetson Counseling or Thorn Counseling.

I permit Jetson Counseling or Thorn Counseling to release information deemed necessary to any insurance or third party payee.

I agree that I am responsible for full payment of this account. I agree to be held responsible for all attorney fees and court costs in the collection of this account.

_____ _____

Responsible Party Date

_____ _____

Patient Date