Early Interventions, L.L.C.

PATIENT INFORMATION AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION

Name: (Last, First, Middle) ________________________ Date of Birth: ______

Address: ________________________ SSN: ____________

City, State, Zip: ________________________ Phone: ____________

PARENT/GUARDIAN (Circle)

Father: ____________________ Mother: ____________________

Address: ____________________ Address: ____________________

City, State, Zip: ____________________ City, State, Zip: ____________________

Phone: ____________________ Phone: ____________________

DOB: __________ SSN: __________ DOB: __________ SSN: __________

Email: ____________________ Email: ____________________

INSURANCE SUBSCRIBER

Policy Holder: ____________________ Employer: ____________________

Address: ____________________ Address: ____________________

City, State, Zip: ____________________ Phone #: ____________________

DOB: __________ SSN: __________

INSURANCE (copy of insurance card required)

Company: ____________________ Phone #: ____________________

I.D. # ____________________ Group #: ________ Effective Date: _____

FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT

I authorize Early Interventions, LLC to release any information acquired in the course of examination or treatment for insurance and consultation purposes only.

I authorize payment of medical benefits directly to Early Interventions LLC, otherwise payable to me for the medical services rendered.

I understand that I am financially responsible for the amount of my bill which is not paid by insurance. If I have no insurance coverage I am fully responsible for the amount of the bill. Collection services may be utilized if payments are not made in a timely manner.

I hereby authorize Amanda Cervantes, M.D. to treat my child/myself.

I have read and agree to the above:

GUARANTOR SIGNATURE: ____________________ **DATE:** ____________

PRINTED NAME: ____________________