Patient Authorization

Patient Name:____ Date of Birth:____________________

SSN:_____________________________ Sex: M / F

Home phone:___________________________________ Cell phone:_____________________________

Street address:____

City:_____________________________State/Zip:_________________________

School District (if applicable):___________________________________

Parent(s)/guardians:____

Address (if different):____

Parent/guardian employer:______________________________________phone:____________________

Child's Physician:______________________________________phone:___________________________

Primary Insurance:__________________________Subscriber/relation to patient:_____________

Policy #:_________________________________Group:____

Phone number:____________________________Address:____

Guarantor's date of birth:__________________________SSN:____________________________________

Secondary Insurance:____________________________Subscriber/relation to patient:________________

Policy #:_________________________________Group:____

Phone number:____________________________Address:____

Guarantor's date of birth:__________________________SSN:____________________________________

I authorize the release of any medical or other information necessary to expedite insurance claims. I hereby assign to Wild Roots Therapy, PC all benefits which are or shall be payable from any third party payor who is responsible for payment of my expenses. I authorize and direct all third party payors to pay all benefits directly to Wild Roots Therapy, PC. I give my consent for my child to receive therapy services prescribed by their doctor and designated by their therapist. **I understand that I am responsible for payment on any account balance not reimbursed by my insurance.**

A 24 hour notice is required for cancellation of an appointment or a treatment fee will be charged.

2110 Overland Avenue, Suite 120 Billings MT 59102
Phone 406-969-1795 FAX 406-969-1796

Parent/Guardian signature:_______________________________________Date:________________

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