CLIENT INFORMATION

NAME ____ DATE OF BIRTH ____________

GENDER ______________ MARITAL STATUS_________________

NAME OF PARTNER ____

NAMES AND AGES OF CHILDREN ____

____

ADDRESS____

CITY ______________________________STATE________________ ZIP________________

PHONE (H)_________________________ (C) ______________________________________

EMPLOYER__________________________ WORK PHONE____________________________

EMERGENCY CONTACT______________________ PHONE____________________________

RELATIONSHIP OF EMERGENCY CONTACT ____

INSURANCE COMPANY____

HOLDER OF INS. POLICY : NAME ___________________________DOB________________

GROUP NUMBER ________________________ ID NUMBER __________________________

Payment Policy

I understand that this office will bill my insurance company on my behalf, but I am fully responsible for all charges incurred. I guarantee payment of all charges, even those denied by my insurance carrier, unless Tamara L. Kaiser LLC's contract with the insurance company does not allow it. I authorize the release of the minimum amount necessary of any personal health information to Cathie Goedert Welch and to the above-mentioned insurance company, in order to obtain payment for services received. I hereby instruct my insurance company to pay directly to Tamara L. Kaiser LLC all benefits allowable and payable under my policy.

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Signature Date