

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 _____

NAME OF INSURED _____

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.

Signature

Date