Strength of Mind

Patient

Name:	DOB:	SSN:	Sex:
Address:	Primary Phone: ☐ Cell ☐ Home	Alternate Phone: ☐ Cell ☐ Home	
City:	State: Zip:	Marital Status:	Preferred Pharmacy and Address:
Email Address: ☐ **Authorized to email appointment reminders**			

Emergency Contact Information

Name:	Relationship:	Phone:

Responsible Party (Parent or Legal Guardian)

☐ Same As Patient	Name:		Relation to Patient:	
DOB:	SSN:	Marital Status:	Sex:	Phone:
Address:	City, State, Zip:			

Insured Party (Insurance Card Holder)

☐ Same as Patient ☐ Same as Parent/LG	Name:	Marital Status:	Sex:
DOB:	SSN:	Employer Name and Address:	
Address:	City:	State:	Zip:

Authorization to Release Information and Assignment of Benefits

I hereby certify that the information I have reported with regard to my insurance coverage is correct. I authorize Strength of Mind to apply for insurance benefits on my behalf for covered services rendered by Strength of Mind. I also authorize the release of any medical information necessary to process all insurance claims. I request the payment from my insurance company be made directly to Strength of Mind or Dr. Clayton Rogers. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

In addition to the releases outlined above, information may be released to the following individuals or organizations for the indicated purpose:

******By signing below, I state that I have read and understand all Strength of Mind's office policy statements and I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.**

Name of patient (please print):_____

Signature: _____ Date: _____

(Patient, Parent, or Legal Guardian)