SONDER

Behavioral Health & Wellness

Date: _____

Patient Information

Patient Name _____ Date of Birth _____
Street Address _____ Home Phone _____
City _____ State _____ Zip _____ Mobile Phone _____
Social Security # _____ Emergency Contact/Number: _____
Sex □ Male □ Female Age _____ Marital Status: _____ Employer: _____
Primary Care Physician _____ Referred by _____

Primary Insurance

Primary Insurance Company _____ Phone _____
Ins Claims Address _____ City_____ State _____ Zip _____
Policy/ID # _____ Group Plan # _____

Policy Holder Information (If the patient is not the policy holder)

Name: _____ Relationship _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Employer _____

Secondary Insurance

Secondary Insurance Company _____ Phone _____
Ins Claims Address _____ City_____ State _____ Zip _____
Policy/ID # _____ Group Plan # _____

Policy Holder Information (If the patient is not the policy holder)

Name: _____ Relationship _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Social Security # _____ Employer _____

Responsible Party (Where should the patient's bill be sent, if not to the patient)

Name _____ Relationship _____
Address _____ Phone _____

_____ _____ _____
Responsible Party Signature Relationship to Patient Date

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above ad assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date