BOSTON SENSORY SOLUTIONS, LLC

CLIENT DEMOGRAPHICS:

Name:		Telephone Number-Home	
Email address:		Telephone Number-Work	
Date of Birth:		Primary Care Physician:	
Patient Status	Single Married Other		
Patient Sex	Male Female		
Patient Address:	Street: City/Town State Zip		
Relationship to Insured			

INSURED'S INFORMATION

Insured's Full Name			
Insured's Address:	Street: City/Town State Zip		
Insured's DOB		Insured's SS#:	

INSURANCE INFORMATION (not needed if a copy of the insurance card is supplied)

	PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Name:		
Address to Mail Claims:	Street: P.O. Box #: City/Town: State: Zip:	
ID#:		
Group #:		
Phone #:		
Patient's diagnosis code(s): (for office use only)		

Cancellation Policy: I acknowledge the necessity of a 48-hour notice for cancellation of an appointment and if I do not notify for cancellation prior to this 48 hours, I will be responsible for the session fee. **Please Initial: _____:**

Release of Information: I authorize the release of any medical or other information necessary to process claims for Boston Sensory Solutions, LLC. Boston Sensory Solutions, LLC has permission to speak with my physician and/or therapist about information pertinent to my care. They may review my medical records and may send a note to my physician or therapist summarizing my treatment.
Please initial: _____

Assignment of Insurance Benefits: I authorize direct payment of benefits to Boston Sensory Solutions, LLC, for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. **Please initial here: _____.**

Signature_____ **Date: _____**
Patient and/or Parent/Guardian