



Patient Name _____
First Middle Initial Last

Mailing Address _____ City _____ State _____ Zip _____

Phone _____ Email Address _____

Social Security # _____ Birthdate _____ Sex _____ (As required by Insurance)
Month/Day/Year M / F

Marital/Relationship Status _____ Employer _____ Work Phone # _____

Spouse/Partners Name _____

Spouse/Partner Cell Phone # _____ Spouse/Partner Work Phone _____

Do we have your permission to call your phone and leave a message? Yes _____ No _____

Do we have your permission to text your cell phone? Yes _____ No _____

Primary Insurance _____ Policyholder _____
Name Birth date

Subscriber Relationship to Patient _____

Insurance Claims Address _____ Phone # _____

Identification / Policy # _____ Group # _____

Secondary Insurance _____ Policyholder _____
Name Birth date

Subscriber Relationship to Patient _____

Insurance Claims Address _____ Phone # _____

Identification / Policy # _____ Group # _____



Mother/Guardian Name _____ Birth date _____
Month/Day/Year

Social Security # _____ Place of Employment _____ Work Phone # _____

Address If Different Than Patient _____ Home Phone # _____

Father/Guardian Name _____ Birth date _____
Month/Day/Year

Social Security # _____ Place of Employment _____ Work Phone # _____

Address If Different Than Patient _____ Home Phone # _____

FINANCIAL AGREEMENT AND TREATMENT AUTHORIZATION

I authorize treatment of the patient named above. I give my explicit authorization to allow Back Office Solutions, LLC to bill my insurance company for services provided to me by Take Control, Inc. DBA Revitalize Health Coaching. I further allow Take Control, Inc. DBA Revitalize Health Coaching and/or Back Office Solutions, LLC to release my health information to my insurance company upon said company’s request, check claim status by contacting my insurance company, and to appeal any claims should my insurance company deny payment for these services. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay all fees and charges for such treatment within 30 days unless credit arrangements have been made. If my debt is assigned to a third party for collection, I am ultimately responsible for payment of all collection fees/costs.

PATIENT SIGNATURE _____
(Parent or Guardian signature if patient is a minor) Date

OFFICE USE:
ICD-10 _____

Special Instructions: _____