

**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 KJO Billing Service 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