**Inner Peace Therapeutic Services, LLC**
**21945 Three Notch Rd Suite 103**
**Lexington Park, Md, 20653**
**Office: 240-718-8460**
**Fax: 240-718-1906**

**(PLEASE PRINT)**

**Client Name**_______________________________________________ Birth date____/____/____Age____

Home Address__________________________________________________________________________

City__________________________________________ State________________ Zip________________

Home Phone _____________________ Work Phone _____________________ Cell _____________________

Email Address________________________________ Social Security # ________________________________

Employer____________________________ Occupation__________________________ Sex: M F

Marital Status: (circle one): Single Married Partnered Separated Divorced Widowed Remarried

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**Parents/Step-parents/Partner/Spouse**________________________________/________________________________
**(Contact Person/Persons)**
Home Phone____________/____________Work Phone____________/____________ Cell____________/____________

Email Address__________________/__________________ Relationship to Patient______________/______________
***(Feel free to use the back of this sheet if more space is needed)***

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**Person Financially Responsible For This Bill**__________________________________ Birth date____/____/____
**(If Different Than Client)**
Home Address__________________________________________________________________________

City__________________________________________State______________Zip____________________

Home Phone _____________________ Work Phone _____________________ Cell _____________________

Email Address ____________________________________ Relationship to Patient________________________

Employer____________________________ Social Security #_____________________________________

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**Primary Insurance Name**_________________________________________________________________

Ins. ID#: ____________________________________/Group#: _______________Co-Payment Amount $_______

Insured's Full Name_____________________________________________________Birth date____/____/____

Home Address__________________________________________________________________________

City__________________________________________State________________Zip________________

Home Phone__________________________________ Work Phone__________________________________

Cell ________________________________________ Relationship to Patient____________________________

Employer____________________________ Social Security #_____________________________________

Authorization #__________________________# of Visits _____Start Date____/____/____Exp. Date____/____/____
(If Applicable)

**Secondary Insurance Name**______________________________________________________________________
**(If Applicable)**
Ins. ID#: _______________________________/Group#: _________________Co-Payment Amount $________

Insured's Full Name _____________________________________________________Birth date____/_____/_____

Home Address______________________________________________________________________________

City___________________________________________________State__________________Zip___________________

Home Phone ____________________________________ Work Phone ___________________________________

Cell ________________________________________ Relationship to Patient_______________________________

Employer______________________________________ Social Security #_____________________________________

Authorization #_____________________________# of Visits _____Start Date____/____/____Exp. Date____/____/____
(If Applicable)
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Please list any previous therapists, therapy and or hospitalizations: ________________________________________

______________________________________________ ____________________________________________________

______________________________________________ ____________________________________________________

Personal Physician__________________________________________________________________________________

How were you referred? Insurance Co. __________ Phone book__________ Web Site___________ Other____________

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| Others living in home | Age | Relationship |
|---|---|---|
| ______________________________ | ______ | __________________ |
| ______________________________ | ______ | __________________ |
| ______________________________ | ______ | __________________ |
| ______________________________ | ______ | __________________ |
| ______________________________ | ______ | __________________ |

*************************************************************************************************************
Briefly describe your reason for this visit:

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

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**Authorization: I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the provider or supplier for services described.**

___________________________________ ________________________________________ ______/_______/_______
(Client Signature) (Parent/Guardian Signature) (Date)