

Inner Peace Therapeutic Services, LLC
23127 Three Notch Rd. Ste 101 and 102
California, MD 20619
Office: 301-866-6333
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

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)

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 # _____

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)

Please list any previous therapists, therapy and or hospitalizations: _____

Personal Physician _____

How were you referred? Insurance Co. _____ Phone book _____ Web Site _____ Other _____

Others living in home	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly describe your reason for this visit:

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)