IRONSTONE THERAPY, INC.
at Ironstone Farm

CLIENT INFORMATION FORM

Client Name:_____ **DOB:** _____ **Gender: M** ☐ **F** ☐

Address: _____
Street City State Zip code

Diagnosis: _____

Referred by: _____ **Phone:**_____

PARENT/GUARDIAN CONTACT INFORMATION
PLEASE COMPLETE IF PATIENT IS A CHILD OR DEPENDENT

Name: _____ **Circle One:** ○ Parent ○ Guardian

Address: _____
Street City State Zip code

Home Phone: _____ **Cell:** _____ **Email:** _____

Parent/guardian 2 Name: _____ **Phone:** _____ **Email:**_____

Payment method: ___ Fee for service/out of pocket ___ Please check for insurance coverage

COVERAGE INFORMATION

Primary Coverage
Insurance Co.: _____ **Phone:** _____
Address: _____
Insurance ID#: _____ **Social Security #:** _____

Subscriber Name: _____ **DOB:** _____ **Sex:** ___ **Phone:** _____
Address: _____
Employer: _____ **Phone:** _____

Relationship of patient to subscriber (circle one): ○ Self ○ Spouse ○ Child ○ Dependent ○ Other

Secondary Coverage
Insurance Co.: _____ **Phone:** _____
Address: _____
Insurance ID#: _____ **Social Security #:** _____

Subscriber Name: _____ **DOB:** _____ **Sex:** ___ **Phone:** _____
Address: _____
Employer: _____ **Phone:** _____

I authorize the release of any health information necessary to process claims. I authorize payment of health care benefits to Ironstone Therapy, Inc. I verify the above information is accurate and understand it is my responsibility to immediately update any changes in my registration information.

Signature: _____ **Print Name:** _____ **Date:** _____