Please note that Altruistic Therapy Services LLC request than any patient information be faxed to 866-886-6628. It is at the patient's discretion to send any personal or medical information via emails and that email is not HIPAA compliant.
INITIALS______

PLEASE SEND A COPY OF THE **GUARANTOR'S** DRIVERS LICENSE AND THE FRONT AND BACK OF THE INSURANCE CARD. WE WILL NOT PROCESS YOUR PAPERWORK WITHOUT THESE ITEMS.

**** Patient's Name:_________________________________ DOB:_____________________________
Address:________________________________ City: ____________________ Zip:____________
Phone:_________________________ Cell:_______________________

**** Primary Care or Referring Physician: __________________________________________
Address: ____________________________________________________________________
Office Phone:________________________ Fax:____________________________________

**** Person Responsible for bill or parent (Complete only if different from the patient)
Guarantor Name:________________________________ DOB:_________________________
Social Security Number__________________________________
Address: _____________________________________________ Phone :________________
Relationship to patent: (   ) Self   (  )Spouse  (   ) Parent  (   ) Other ___________________
If the patient is a minor, please state custodial parent's name: _______________________

**** If Auto or Workers Comp Related: N/A ________ Auto: ____________ WC: _____________ DOI: _____________________
Claim Number: _______________________________
Insurance Carrier: ____________________________

**** Primary Insurance: - If NOT AUTO OR WORKERS COMP RELATED
Name:___________________________ Subscriber Name:_______________________________
Contract Number: ________________ Group Number:________________________________

**** Secondary Insurance: - IF NOT AUTO OR WORKERS COMP RELATED
Name:___________________________ Subscriber Name:_______________________________
Contract Number: ________________ Group Number:________________________________

Third Insurance:
Name:___________________________ Subscriber Name:_______________________________
Contract Number: ________________ Group Number:________________________________

***Authorization to Pay Benefits to Altruistic Therapy Services:*** *I hereby authorize payment directly to Altruistic Therapy Services, LLC of the Therapy benefits, if any, otherwise payable to me for their services as described below but do not exceed the reasonable and customary charge for those services. I understand the provider's charge may exceed the private insurance carrier payment, and if greater than such payment, I will be responsible for that amount, and /or any deductibles or co-pays.Payment is due at the time of service, unless arrangements are made in advance.*

***Authorization to Release Information****: I hereby authorize Altruistic Therapy Services, LLC to release any information required by my health insurance company to pay my medical claims. As related to my examination and treatment.*

*Signature:*________________________________________________*Date:*______________________

***HIPAA Confirmation****: I confirm that I have received / downloaded the HIPAA documentation. If you have not yet downloaded the HIPAA documentation please visit the following link: https://www.altruisticsls.com/wp-content/uploads/2018/09/HIPAA.pdf*

*Signature:*________________________________________________*Date:*______________________