Simply Thrive Therapeutic Associates, PLLC

1200 SE Maynard Rd Suite 103

Cary, NC 27511

Phone (919) 636-0762 Fax (513) 826-9314

Name_____Date_____

First Middle Last

Address_____

City_____State_____Zip_____

Home Phone_____ May I leave you a message? _____

Work Phone_____ May I leave you a message? _____

Other Phone_____ May I leave you a message? _____

Social Security #_____Date of Birth_____

Employer/School_____Full/Part time_____

Email_____ Legal Status__Single__Married__Divorced__Cohabitating

Insurance Company_____

Address_____

Phone Number_____ Authorization_____

Patient ID #_____ Group #_____

Group Name_____Employer/School_____

Who carries this policy? _____

First Middle Last

Address_____ City_____ Zip_____

Social Security #_____Sex___ Date of Birth_____

Relationship to client_____

Secondary Insurance Company information please ask for a separate form

(Please turn over)

How did you hear about my practice? Check all that apply

__Referral from other professional _____

__Referral from a friend_____

__Referral from insurance company_____

__Internet search/phone book _____

__Psychologytoday/webpage_____
_

__Other_____

Send billing statements to: _____

Address_____City_____Zip_____

Emergency Contact_____Phone_____

Primary Care Physician_____Phone_____

FOR TRICARE ONLY Referring physician and NPI number_____

I, the undersigned, certify that I have insurance with _____
Name of insurance company

And assign directly to Simply Thrive Therapeutic Associates, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not.

_____Date_____

Client or Parent's Signature

I hereby authorize Simply Thrive Therapeutic Associates, PLLC to release all information necessary to secure the payment of benefits and coordinate care. I authorize the use of this signature on all insurance submissions.

_____Date_____

Client or Parent's Signature

_____Date_____

Therapist's Signature