

| CLIENT INFORMATION | | | | | |
|--|-------|-------------------|--|------------------------|----------|
| Name | | Birth Date | <input type="checkbox"/> Male <input type="checkbox"/> Female | Social Security Number | |
| Street Address | | City | | State | Zip Code |
| School | Grade | Employer | | Work Phone () | |
| Referred by | | Primary Physician | | Home Phone () | |
| Reason for Appointment | | | | Cell Phone () | |
| E-Mail Address | | | | | |
| Emergency Contact Name and Relationship | | | | | |
| Emergency Contact Address | | | Emergency Contact Phone | | |
| Guardianship Information (if applicable) | | | | | |
| INSURANCE INFORMATION | | | (Please provide your insurance card to be copied) | | |
| Insurance Provider | | | | | |
| Member's Name | | Birth Date | Employer | Group number | |
| Policy Number | | | Client's Relationship to Member | | |
| Person Responsible for Bill and Address, if different from above | | | | | |
| Your Signature | | | | | |
| <p>Acknowledges:</p> <ul style="list-style-type: none"> · Accuracy of above information and <u>financial responsibility</u> to pay any balance and fees for attorney if required for account collection · Receipt and agreement to abide within Dr. Parker's <u>Outpatient Service Contract</u> (revised 1-1-04) · Receipt of <u>HIPAA and State of Alabama policy and practices</u> to protect your health information <p>Authorizes:</p> <ul style="list-style-type: none"> · Consent for me or my minor child to be evaluated and/or treated by Dr. Kinta Parker · Dr. Parker to <u>release information required to process my insurance claim</u> and for insurance benefits to be paid to Dr. Parker | | | | | |
| _____ Printed Name of Client/Guardian | | | _____ Date | | |
| _____ Signature of Client/Guardian | | | _____ Relationship to Client (if not client) | | |
| _____ Witness | | | _____ Date | | |