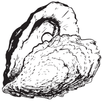

SARAH DIEHL
THERAPY

New Patient Information

Name ______________________________ Date of Birth ____________________

Gender ______________ Mailing Address

Relationship Status ______________________ ______________________

Phone *Primary* ______________________ ______________________

Other ______________________ ______________________

Email Address ______________________ ______________________

Emergency Contact

Name ______________________________ Relationship ____________________

Phone *Primary* ______________________ *Other* ______________________

Referral Source

Please let me know how you learned about my practice.

____

Guarantee of Payment

I, ______________________________, *(name as it appears on credit card)* understand payment is due to Sarah Diehl Therapy, LLC, at the time of services rendered. In the case of any outstanding balances on my account at the end of a calendar month, I authorize Sarah Diehl Therapy, LLC, to charge the credit card specified on this document for the balance due. I maintain that all information provided on this document is valid and that it is my responsibility to update this information with any changes.

Credit card number ____

CCV code: ______ Expiration date ______________ Zip code______________

☐ Master Card ☐ Visa ☐ American Express ☐ Discover

DO NOT PROVIDE HSA/ FSA CARD INFORMATION

Account billing address *(if different from above)* ______________________

____

____

____

Signature

By your signature, you indicate the following: you have read my Payment and Privacy Practices and had the opportunity to ask questions about them, and you agree to pay for treatment and any associated costs and fees.

______________________________ ______________________

Patient *Date*