Aspire Wellness, LLC 6053 S. Quebec St. Suite 100 Centennial, CO 80111 303-872-7344

# Client Information Sheet

**Client Name:** _____

**Date of Birth:** _____

**Street Address:** _____

**City/State/Zip:** _____

**Cell Phone:** _____ **Messages okay? Y or N**

**Home Phone:** _____ **Messages okay? Y or N**

**Other Phone:** _____ **Messages okay? Y or N**

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**Primary Insured:** _____ **Relation to Client:** _____

**Employer:** _____ **Date of Birth:** _____

**Street Address:** _____ **City/State/Zip:** _____

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**Primary Insurance:** _____ **Phone#:** _____

**Visits Authorized:** _____ **Copay:** _____

**Member ID#:** _____ **Group Number:** _____

**Authorization #:** _____ **Client Number:** _____

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By signing below, I agree to the following: (1) I understand that the client is ultimately responsible for the cost of all services rendered. (2) As a service to me, Aspire Wellness, LLC/ Debora Arrera, may bill my insurance company on my behalf. However, I am responsible for verifying insurance coverage and obtaining any necessary pre-authorization. If I fail to do so, I will pay the provider's full customary fees for all services rendered. (3) I authorize the release of any information necessary to process insurance claims (4) I authorize my insurance company to pay Aspire Wellness, LLC/Debora Arrera directly for the services provided to the client. (5) I will pay the appropriate co-payment or coinsurance to the provider at the time service is rendered. (6) I understand that I will be billed for missed appointments that are not cancelled at least 24 hours in advance and that I am responsible for paying those charges.

_____ _____

**Signature of client/guardian** **Date**

***Diagnosis Code:***_____