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**

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

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

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

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

Copay: _____

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

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:_____