Robert M. DuWors, Ph.D.

162 Hegeman Ave

Colchester, VT 05446

Telephone: (802) 876-7613

Fax: (802) 876-7813

Patient Name: ____ Date: _______________________

Age: ______ DOB: ____________ Sex: ☐ M ☐ F Marital Status: ______ SSN: __________________________

Home Address: _____________________________ Town: _________________ State _____ Zip ____________

Phone: __________________________

If Child: Parent/Guardian ____

Emergency Contact: _______________________________________ Phone: ___________________________

Primary Care Physician: ____________________________________ Phone: ___________________________

Email Address:____

I consent for treatment of the above named patient: ____

(signature)

☐ Self ☐ Parent/Guardian ☐ Other: ____

____

(Witness Signature)

INSURANCE INFORMATION

Source of Payment: ☐ Insurance ☐ Self Pay $ ____________ per session

Primary Insurance:

Insurance Co: ____________________________ Subscriber Name: ____________________________

Policy #: ___________________________ Address: ____

Group #: ___________________________ ____

Relationship of Client to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____________________

Secondary Insurance:

Insurance Co: ____________________________ Subscriber Name: ____________________________

Policy #: __________________________ Group #: ____________________________

Relationship of Client to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: ____________________

INSURANCE AUTHORIZATION AND AGREEMENT:

I hereby authorize Dr. Robert M. DuWors to furnish information to insurance carriers concerning myself and/or dependent's condition and treatment and I hereby assign to the provider all payments for medical services rendered to myself and dependents. **I understand that I am solely responsible for keeping my insurance current and to notify Dr. Robert M. DuWors of any changes in my coverage.**

Signature: _________________________________ Date: ______________________