



Sanctuary for Healing and Integration, PLLC (SHIN)

Child & Adolescent and Adult Psychiatry
860 East 4500 South, Suite 302
Salt Lake City, UT 84107

Provider Name	Referred by	PT Account #	Diagnosis

PATIENT: Please complete all information; please print clearly

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	MARITAL STATUS M S D W
ADDRESS		CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	SOCIAL SECURITY #	DATE OF BIRTH	
E-MAIL ADDRESS		OCCUPATION		
EMPLOYER			WORK PHONE	
EMPLOYER'S ADDRESS				
NAME OF NEAREST RELATIVE (not living with you)		RELATIONSHIP	PHONE	

RESPONSIBLE PARTY INFORMATION (if not patient)

FIRST NAME	MIDDLE INITIAL	LAST NAME	SEX	MARITAL STATUS M S D W
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK/MOBILE PHONE(S)	SOCIAL SECURITY #	DATE OF BIRTH	
E-MAIL ADDRESS		EMPLOYER		
EMPLOYER'S ADDRESS			OCCUPATION	

INSURANCE INFORMATION (including Medicare)

INSURANCE COMPANY #1	POLICY NUMBER	GROUP NUMBER	
INSURANCE ADDRESS		PHONE	
INSURED'S NAME	RELATION TO PATIENT	DATE OF BIRTH	SEX
INSURANCE COMPANY #2	POLICY NUMBER	GROUP NUMBER	
INSURANCE ADDRESS		PHONE	
INSURED'S NAME	RELATION TO PATIENT	DATE OF BIRTH	SEX

IN CASE OF EMERGENCY:

NAME	PHONE
ADDRESS	

I, the undersigned, give permission to release information to 3rd party carrier(s) and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

*I, the undersigned recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay up to an additional **50% of cost collection** including agency and attorney fees and court costs incurred and permitted by laws governing these transactions. A finance charge of 1.5 percent per month (annual rate of 18 percent) will be charged on all balances over 30 days, regardless of pending insurance claims.*

Date

Signature of responsible party