Reigning Hope Therapy Services

Farm Clinic

Face Sheet

First Name_____**MI** _____ **Last Name**_____

Birthdate_____ **Age** _____ **SSN#**_____ **Sex: M**_____ **F**_____

Address_____**Apt** _____

City_____**State**_____**Zip**_____

Home Phone_____ **Cell/Other Phone**_____

Email_____

Parent/Guardian/Spouse: (Responsible Party)
Name_____ **Birthdate** _____
Address: _____
City_____ **State**_____ **Zip**_____

Parent/Guardian/Spouse: (Responsible Party)
Name_____ **Birthdate** _____
Address: _____
City_____ **State**_____ **Zip**_____

Emergency Contact: _____**Relationship**_____ **Phone** _____

Primary Care Physician _____

INSURANCE INFORMATION

Primary Insurance _____**Policy #** _____
Policy Owner SS# if Policy #

Policy Owner _____ Birthdate _____

13039 Falcon Hwy, Peyton, Colorado 80831
www.reigninghope.net kesti@reigninghope.net
p: 719-209-3365 f: 719-960-2139

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Secondary Insurance _____ Policy # _____

Policy Owner SS# if Policy #

Policy Owner _____ Birthdate _____

____Medicaid -- please provide PASSPORT PROVIDER: _____ Auth _____

____Work Comp (complete attached info sheet) Date of Injury _____

I authorize the release of any medical or other information to process this claim. I understand that, although insurance may or may not cover part of my charges, I am responsible for payment, and I authorize payment of my insurance to be paid directly to the provider.

_____ _____

Responsible Party Signature **Date**

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