East Wind Therapies, Inc
1954 Howell Branch Road, Suite 112
Winter Park, FL 32792
407.677.9993

Date: _____

Name _____ Date of Birth_____

Address _____

_____

Phone Day (____)_____ Evening (____)_____

CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____

Phone Day (____)_____ Evening (____)_____

ASSIGNMENT OF BENEFITS

I understand that East Wind Therapies, Inc. may file an insurance claim on my behalf for reimbursement of services rendered, if benefits are applicable. I _____ authorize the payment of these medical claim benefits to East Wind Therapies Inc.

Signed _____

Date _____

FINANCIAL RESPONSIBILITY

I understand that I am responsible for all fees connected with services rendered by East Wind Therapies, Inc. and agree to make payment in full at the time services are provided. Should there be any prior arrangement made with the office regarding payment for services rendered, I am aware that I am liable for all legal expenses incurred with the collection of my account.

Signature of Client or Guardian _____ Date _____