Macintosh HD:Users:christopherobara:Desktop:Chris:Ventures:Amy Albero LLC:Branding:revive:for_print:revive.pdf

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Number : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

**PAYMENT OPTIONS**

Please select a payment option:

□ Private Pay or Out-of-Network Insurance Reimbursement: This option requires full payment at time of service.

Please select the preferred method of payment:

○ Cash/Check

○ Credit/Debit Card: Please fill out Credit/Debit Card Section.

○ Paypal (Payment@ReviveCFW.com)

□ Insurance Reimbursement (In-Network): This option may require a copayment at time of service.

If you have a copayment, please select the preferred method of payment:

○ Cash/Check

○ Credit/Debit Card: Please fill out Credit/Debit Card Section.

○ Paypal (Payment@ReviveCFW.com)

**CREDIT/DEBIT CARD INFORMATION**

Type of Card: □Mastercard □Visa □Amex

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration: \_\_\_/\_\_\_\_ Security Code (CSC): \_\_\_\_\_\_\_\_\_\_\_\_

Name (as it appears on card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Services Phone # (on back of card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**INVOICE OPTIONS**

Revive Center for Wellness generates monthly session invoices at the end of each month. Please specify whether you would like a copy of your invoice, and the method of delivery.

□ Yes, please send me monthly invoices for my sessions.

Method of Delivery:

○ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

○ USPS Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No, I do not require monthly invoices to be provided to me.