

The following form is to be filled and faxed to 844-394-2533 or emailed to cs@freespira.com.

PRACTITIONER'S INFORMATION			
Name:	[Enter First M. Last Name]		
Address:	[Enter Address or PO Box]		
City:	[Enter City]	State:	[Enter State] Zip: [Enter Zip]
Phone:	[Enter Area Code & Number]	<input type="checkbox"/> Mobile	<input type="checkbox"/> Landline
Email:	[Enter Email Address]		
NPI or State License:	[Enter National Provider Identifier or States License Number]		

PATIENT INFORMATION			
Name:	[Enter First M. Last Name]	Date of Birth:	[Select Date]
Address:	[Enter Address or PO Box]		
City:	[Enter City]	State:	[Enter State] Zip: [Enter Zip]
Insurance:	[Enter Company Name]	Group #:	[Enter #] ID#: [Enter #]
Phone (required):	[Enter Area Code & Number]	<input type="checkbox"/> Mobile	<input type="checkbox"/> Landline
Email (required for receipts):	[Enter Email Address]		
Patient Disease State:	<input type="checkbox"/> Panic	<input type="checkbox"/> PTSD	

Additional Comments:

**** Patients diagnosed with COPD are not eligible for Freespira treatment.**