Psychological & Counseling Associates * Insurance Information

PLEASE COMPLETE ALL AREAS/PAGES IF YOU HAVE ANY QUESTIONS PLEASE ASK THE OFFICE STAFF AND THEY WILL ASSIST YOU.

Client Name: _____Birthdate: ____/____/____Sex: [ ] Male [ ] Female

Mailing Address: _____ May we use for mailing purposes? [ ] Yes [ ] No

City: _____ State: _____ Zip _____ SS#_____(18yrs-Up)

Home Phone #: _____ Work _____Cell Phone: _____

Okay to call and or leave messages at [ ] Home [ ] Work [ ] Cell Marital Status: [ ] S [ ] M [ ] D [ ] W

E-mail:_____ Spouse: _____

Referred By: _____Primary Care Doctor _____ Phone: _____

Nearest relative not living in same household: Name _____Phone #:_____

PARENT OR GUARDIAN INFORMATION (Responsible Party)

Parent/Guardian/Guarantor: _____ Birthdate: _____ Sex: [ ] M [ ] F

Address: _____City: _____State: _____ Zip: _____Phone#: _____

SSN#: _____ Work Phone #:_____ Occupation: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship to Client: _____ E-mail _____

INSURANCE INFORMATION (Policy Holder's SS# is Required)

Primary

Policy Holder's Name: _____ Birthdate: __/___/___ Sex: [ ] Male [ ] Female

Address: _____City: _____State: _____ Zip: _____Phone#: _____

Employer: _____ Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

SS# of Insured: _____ Relationship to Client: _____

Secondary

Policy Holder's Name: _____ Birthdate: ___/___/____ Sex: [ ] Male [ ] Female

Address: _____City: _____State: _____ Zip: _____Phone#: _____

Employer: _____ Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

SS# of Insured: _____ Relationship to Client: _____

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/client/guardian is still responsible for co-pays or unpaid balances. Collection fees, due to any unpaid balance, is the responsibility of the Guarantor/client/guardian.

Insurance Authorization/Release of Information: I authorize any holder of Psychological or other information about me to release said information to health care financing administration and its agents any information needed to determine these benefits for related services. I authorize payment to be paid directly to **The Provider.** This is a lifetime authorized signature which may be revoked in writing at any time. ***PLEASE SIGN BOTH LINES BELOW***

Guarantor/Client/Guardian:_____ __ Date: _____

Receipt of Privacy Practices: _____Date: _____