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#_____

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 _____

Nearest relative not living in same household: Name _____

Address: _____ Relation: _____ Phone #:_____

Parent or Guardian Information (Responsible Party)

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

Mailing Address: _____ Street Address: _____

City _____ State: _____ Zip _____ Home Phone #: _____

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

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____

Relationship to Client: _____ E-mail _____

INSURANCE INFORMATION

Primary

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

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Employer: _____ Insurance Carrier: _____

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

SS# of Insured: _____ Relationship to Client: _____

Secondary

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

Mailing Address: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Home 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*** Privacy Practices are located on the website and at the front desk for review. You may request a printed copy for your records.

Guarantor/Client/Guardian:_____ __ Date: _____

Receipt of Privacy Practices: _____Date: _____