Patient and Billing Information

**Patient Name_____
First MI Last

Address_____
Street Apt. #

_____
City State Zip

Phones _____
Home Cell Work

**Birthdate _____ Female___ Male___

Employer_____Occupation_____

Primary Care Physician : _____
Referred By: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____
Current Medications: _____
Known Allergies: _____

PRIMARY INSURANCE

Person responsible for account: _____
Relationship to patient: _____ Birthdate: _____SSN: _____

**Patient's Primary Insurance: _____
Group # : _____ ***ID # : _____
Secondary Insurance: _____ Subscriber: _____
Group # : _____ ID # : _____

HAVE YOU CONTACTED YOUR INSURANCE COMPANY AND VERIFIED YOUR ELIGIBILTY FOR MENTAL HEALTH BENEFITS? Yes No

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY,AND RELEASE OF INFORMATION

I hereby give my consent for psychiatric & psychological consultation & treatment. I agree to be financially responsible for cancelled appointments in accordance with my doctor's cancellation policy. I authorize insurance benefits to be paid directly to the doctor and that the doctor may release any information to my insurance provider required for processing my claims. This release and authorization will remain in effect indefinitely.

Signature of Patient or Guardian: _____Date: _____

Printed Name: _____