psych care associates, p.c.

PATIENT INFORMATION

Patient Name_____ SS# _____

Address_____

City_____ State_____ Zip_____

Phone_____ Cell_____

DateofBirth_____ Sex (please circle) M /F

Employer/School_____

Employer/SchoolAddress_____

EmergencyContact_____ Relationship toPatient_____

Phone_____ Cell_____

Primary CarePhysician_____ PCPPhone_____

How did you hear about us? _____

IauthorizePsychCareAssociates,P.C.toreleaseinformationnecessarytoprocessmyinsuranceclaim.

Date_____ Signature _____

INSURANCEINFORMATION

Name_____ DateofBirth _____

SS# ofPolicyHolder_____ Relationship toPatient_____

PrimaryInsurance_____ ID#_____

SecondaryInsurance_____ ID#_____

Name of Policy HolderEmployer_____

Address of Policy HolderEmployer_____

City_____ State_____ Zip_____

ASSIGNMENT OFBENEFITS

I request and authorize that payment of medical benefits in consideration to the attached claim be made directly to PsychCare Associates, P.C. by insurance carrier(s) as statedabove.

Further,Iacknowledgeresponsibilityforanydeductibleorcoinsurancedesignatedand/ornotpaidbyinsurer.

Date_____ Signature _____