Adult
11/2023

PSYCHOLOGY HEALTH GROUP

A Group of Independent Practitioners

Family Physician_____ Referred by_____

Legal Full Name_____ Age_____Birthdate _____/_____/_____
Preferred Name_____ Gender_____
Address_____ City_____ State_____ Zip_____
Home Phone _____ Cell Phone _____ SS#___-___-_____
Single____ Married_____ Divorced_____ Legally Separated_____ Widowed_____
Work Full-Time___Work Part-Time___Unemployed___Retired___Full-Time Student___Part-Time Student___
Employer_____ Occupation_____ Work Phone _____

Spouse/Partner/Significant other_____Cell Phone _____
Employer_____Occupation_____Work Phone _____
Who may we contact in case of emergency or appointment change and cannot reach you?
Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

INSURANCE INFORMATION-Please complete in full. Insurance billing is a courtesy. It is important that we have all necessary insurance information in order to submit your claims correctly.

Primary Insurance or EAP_____Policy Number _____Group Number _____
Claims Address_____ Authorization# _____
Policy Holder _____ Policy Holder's Birthdate_____ Employer _____

Secondary Insurance_____ Policy Number_____ Group Number_____
Claims Address_____ Authorization#_____
Policy Holder_____ Policy Holder's Birthday_____ Employer _____

PATIENT RIGHTS AND RESPONSIBILITIES

I have reviewed Psychology Health Group's brochure which outlines policies with regard to patient rights and responsibilities. I acknowledge that I have been provided an opportunity to ask questions regarding this policy. **I agree to contact my insurance company to determine if authorization is needed.** I also understand that the patient or other responsible party is responsible for payment of fees unless otherwise agreed upon. I direct the insurer to pay, without equivocation, directly to Psychology Health Group all benefits due as a result of visits at Psychology Health Group. I further understand that I may be charged for any missed appointments or for appointments that are cancelled without sufficient notice. I also understand that failure to meet the financial obligations related to coming to the office may result in disruption of services and/or being turned over to a collection agency.

I give my consent to be treated at Psychology Health Group.

RELEASE OF INFORMATION

I authorize Psychology Health Group to release information necessary for billing only to my insurance company and/or financially responsible party. I authorize Psychology Health Group to release treatment plans necessary for authorization to my insurance company. **I also authorize Psychology Health Group to release information to the referring individual or organization and to my family physician.** I further acknowledge and authorize that my records may be anonymously reviewed by other members of Psychology Health Group for the purpose of treatment review and crisis management.

Signature_____ **Date** _____

Signature_____ **Date**_____