

Child  
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/Cell Phone \_\_\_\_\_ School Attending \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Parent/Guardian SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Parent/Guardian SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Who may we contact in case of emergency or appointment change and cannot reach you?

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 \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

