DATE _____

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____ SEX _____

PATIENT'S SS# _____ REFERRED BY _____ PATIENT'S OCCUPATION _____

PATIENT'S ADDRESS: _____

CITY _____ STATE _____ ZIP _____ MARITAL STATUS _____

TELEPHONE: H: _____ W: _____ C: _____

PERSON NOT LIVING WITH YOU TO CONTACT IN EMERGENCY _____ PHONE _____

INSURED'S NAME: _____ INSURED'S SS# _____ INSURED'S BIRTHDATE _____

RESPONSIBLE PARTY INFORMATION

Only fill out this section if the patient is a minor or someone other than the patient is responsible for payment. If someone other than the patient is responsible for payment of services, a Financial Agreement MUST be signed by the Responsible Party.

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

HOME ADDRESS OF RESPONSIBLE PARTY _____

CITY _____ STATE _____ ZIP _____ MARITAL STATUS _____

RESPONSIBLE PARTY'S TELEPHONE: H: _____ W: _____ C: _____

SS#: _____ RESPONSIBLE PARTY'S EMPLOYER _____

HOW MAY WE CONTACT YOU?

What telephone numbers may we call to confirm appointments?

PATIENT: H W C Do Not Confirm (Circle all that apply)

RESPONSIBLE PARTY: H W C Do Not Confirm (Circle all that apply)

Should correspondence be sent to the patient's address or the responsible party's address?

(Circle One) Patient Responsible Party Neither

If you answered "Neither," please provide us with an alternate address in which to send correspondence.

_____

By signing below you agree that we may contact you in the manner indicated above.

Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the therapist and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

This office request an assignment of benefits for our files, should your account become delinquent, requiring this office to receive the insurance reimbursement.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to: CONSTANCE AVERY-CLARK, PH.D., LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Name: _____ Signature: _____ Date: _____