Powers Ferry Psychological Associates, L.L.C.

PATIENT INFORMATION

Patient's Name ______________________ Sex ___ Date of Birth ___/___/___ Age_____

Employer/School ______________________ SSN ______________

Home Address ______________________________________

City ______________________ State ______ Zip ______________

Phone ~ Home (_____)-______________ Work (____)-______________ Cell (___)-______________

E-mail ______________________

If patient is a minor: Names of Parent(s)/Guardian(s)______________________

RESPONSIBLE PARTY INFORMATION

☐ Check if same as patient (skip this section)

Guardian Name ______________________ Sex ___ Date of Birth ___/___/___

Relation to Patient ____________ Party's SSN ______________ Employer ______________

☐ Same address as the Patient ☐ Different address than the Patient *(Please complete address below)*

Street Address ______________________________________

City______________________ State ______ Zip ______________

☐ Same home phone as the Patient ☐ Different home phone: Home (____)-______________

Other Phones: Work (_____)-______________ Cell (____)-____________Email ______________

INSURANCE INFORMATION ~ Please Provide Insurance Card ~

Policyholder's Name______________________Policyholder's SSN ______________

Date of Birth ___/___/___ Primary Insurance Co. Name ______________________

Insurance Company's Customer Service Phone # ______________Insurance ID # ______________

Policyholder's Employer:______________________Group #______________

Co-pay $______________ Deductible? ☐ Yes ☐ No Amount $______________

Authorization Required? ☐ Yes ☐ No Authorization # ______________________

Number of Sessions Authorized __________ Maximum Number of Sessions Allowed Per Year__________

Is the patient covered under a secondary insurance policy? ________ *If yes*, please see the applicable paragraph under the Insurance Reimbursement section in the following agreement.

How did you hear about us?

Friend/Relative:______________ Health Professional:______________

Website:______________ Insurance Company:______________