PATIENT INSURANCE INFORMATION AND RELEASE

Name____**DOB**____________**M**_____**F**_______
Last First Middle

Home Address____
Number Street (Apt) City State/Zip

Phone (____)______________________________ (____)_______________________________
Home Cell

Social Security #____________________________ **Driver's License #** _________________________

(If Different From Above)
Responsible Person_________________________________Relationship__________________________

Social Security #________________________________Driver's License#_________________________

Insurance Company ______________________________**Phone** (____)_________________________

Certificate # __________________________________ **Group #** _____________________________

Employer ____________________________________ **Phone** (____)_________________________

FINANCIAL RESPONSIBILITY

I authorize the treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay my co-pay at the time services are rendered. I hereby authorize the provider to release all information necessary to secure the payment of benefits to outside agencies. I authorize the assignment of benefits to be paid to the provider. In the event legal action is necessary to collect unpaid balances, I agree to pay reasonable attorneys' fees and other such costs as the court determines proper.

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, the patient, not the insurance company, is responsible and will be billed according to the scheduled fee. If for any reason, your insurance company does not cover charges, you are ultimately responsible for all charges incurred.

Signature____**Date**_____________

Mary Ann Nugent, Psy.D.