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Psychotherapeutic Solutions, LLC
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NY State License#: 016025-1
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PATIENT INFORMATION

Name:_______________________________________ Age:_______ DOB:______________

Address:____________________________________ City:______________________________

State:_____ Zip Code:________

Telephone Number: (H)__________________________________

(Work)______________________________

(Cell)_______________________________

EMPLOYMENT/SCHOOL INFORMATION

Occupation:_____________________________ Employer:____

Work Address:____

Work Telephone Number:_______________________________________ Ext.______________________

Name of School:____ Grade:_____________

SPOUSE/SIGNIFICANT OTHER INFORMATION

Marital Status: M S W D Other:__________________________________

Name:_______________________________________ Age:_______ DOB:______________

Address:____________________________________ City:____________________ State:_____

Telephone Number: (H)__________________________________

(Work)_____________________________

(Cell)_______________________________
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RESPONSIBLE PARTY INFORMATION (IF APPLICABLE)

Name:_____ **Name:**_____

Relationship:_____ **Relationship:**_____

Address:_____ **Address:**_____

Telephone:_____ **Telephone:**_____

EMERGENCY CONTACT:_____

Relationship:_____ **Telephone #**_____

Address:_____ **City:**_____ **State:**_____

INSURANCE INFORMATION

Your insurance is a method for you to receive reimbursement for fees you have paid to Alfredo Lowe, Ph.D. for services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances based on your contract with them. Please call your insurance carrier to become informed of your out-of-network, outpatient mental health benefits. Your carrier will provide you with your coverage information and will quote a percentage, such as "70% of usual and customary," although this does not necessarily mean this office's fee. We will assist you in receiving reimbursement, but you are responsible for your bill.

Primary Insurance Company:_____

Mailing Address:_____

ID#:_____ **Group#:**_____ **Effective Date:**_____

Subscriber's Name:_____

Patient's Relationship to the Subscriber: Self_____ Spouse_____ Child_____

Subscriber's Date of Birth:_____

Secondary Insurance Company:_____

Mailing Address:_____

ID#:_____ **Group#:**_____ **Effective Date:**_____

Subscriber's Name:_____

Patient's Relationship to the Subscriber: Self_____ Spouse_____ Child_____

Subscriber's Date of Birth:_____

I/We assume responsibility for all charges incurred. I/We understand payment is due at the time of visit unless a payment arrangement has been previously established.

Patient's Signature_____ **Date:**_____

Responsible Party's Signature_____ **Date:**_____