Spectrum Psychological Associates, Inc.
Patient & Insurance Information

PATIENT INFORMATION

Patient Name _____

Patients S.S. # _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ Home Phone # _____

Work Phone # _____ Cell Phone # _____

PLEASE ONLY LIST NUMBERS WHERE WE CAN CONTACT YOU OR LEAVE A MESSSAGE

E-Mail Address _____

INSURANCE INFORMATION

Insurance company Name _____

Name of Insured _____ Date of Birth _____

Insured's S.S. # _____ Group # _____

I.D. # (if different than S.S. #)_____

Relationship to Insured _____ Employer _____

Did you obtain authorization? _____ Auth # _____# visits ____

I verify that the insurance information given is correct as of the date below. I understand that if I do not provide accurate information or if my insurance company does not cover my services, I will be responsible for full payment of these mental health services. I authorize Spectrum Psychological Associates, Inc. to file claims to my insurance company. I also authorize Spectrum Psychological Associates, Inc. to release medical information necessary to process my claims and authorize the insurance company to pay Spectrum psychological Associates, Inc. directly for my services.

_____ _____

Date Signature of patient or guardian of minor