PATIENT INFORMATION: (Please Print) Provider name _____

Patient Name:

_____
(Last) (First) (Middle Initial)

Home Address: _____ Apt # _____

_____
City State Zip Code

Home Phone #: _____-_____-_____ Other Phone #: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/ _____/ _____ Social Security Number: _____-_____-_____
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partner

Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Name of Employer / School: _____

Previous Mental Health Treatment (within 2 years): ☐ Psychiatrist ☐ Psychologist ☐ LCSW-C ☐ Other
Mental Health Provider: Name: _____ Phone: ____-____-_____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID Policy #: _____ Group #:_____

Claims Address: _____ Phone #: _____-_____-_____

Policy holder's Name: _____ Date of Birth: ____/____/_____
Month Day Year

Social Security #: _____ Effective Date of Insurance: _____ /_____/_____
Month Day Year

Policy Holder's Employer: _____ Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other

_____ Date of Birth: ____/_____/_____ Phone # _____-_____-_____
Name (if different from patient)

Secondary Insurance (Medicare Patients only) _____ID Policy # _____

Policy Holder Name: _____ Date of birth:_____/_____/_____

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize ProPsych Billing Solutions, LLC to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed _____ Date_____