Anne B. Parsons, Ph.D.

NAME:____ D.OB.___________________

ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE: HOME ________________________ WORK _________________________
OTHER ___________________________

PATIENT'S SS# ______________________ MARITAL STATUS: _______________

EMPLOYED BY: ______________________ POSITION: _________________ PT/FT

REFERRED BY: ____

FAMILY PHYSICIAN: ____

KNOWN MEDICAL PROBLEMS, CURRENT MEDICATIONS: _________________

____

PERSON TO CALL IN AN EMERGENCY: ___________________________________

PHONE# ______________________________ RELATIONSHIP: __________________

INSURANCE INFORMATION

INSURANCE COMPANY:____

TYPE OF INSURANCE PLAN (HMO, PPO, ETC.): _____________________________

INSURED PARTY: __________________________ RELATIONSHIP TO PARTY ____

INSURED'S SS# ____________________________ INSURED'S D.O.B.: ____________

PATIENT'S ID#: ____________________________ GROUP #: ____________________

PREAUTHORIZATION REQUIRED? (CIRCLE): YES NO DON'T KNOW

AUTHORIZATION #: ____________________________ NO. OF SESSIONS: ______

CONTINUE ON REVERSE SIDE

SECONDARY INSURANCE CO:____

TYPE OF INSURANCE PLAN (HMO, PPO, ETC.): ____________________________

INSURED PARTY: _________________________ RELATIONSHIP TO PARTY ____

INSURED'S SS# ___________________________ INSURED'S D.O.B.: ____________

PATIENT'S ID#: ___________________________ GROUP #: ____________________

PREAUTHORIZATION REQUIRED? (CIRCLE): YES NO DON'T KNOW

AUTHORIZATION #: ___________________________ NO. OF SESSIONS: ______

[ ] I am not using medical insurance, either because ( ) I do not have insurance presently, or ( )I choose to not use my insurance. Therefore, I am required to pay in full for services at the time those services are provided (the fee for service rate is $140/$160 per session).

OR

[ ] My insurance is an HMO, PPO, (or other plan) with which Dr. Parsons is a contracted provider. I am required to pay any known deductible or co-payment at the time of service, and Dr. Parsons will submit claims directly to my insurance company for the balance. (Please note that you will be responsible for any additional balance should your insurance refuse the claim, impose an unanticipated deductible or other unforeseen insurance limitation).

INSURANCE CONSENT

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or insurance information necessary to process this claim. I also request payment of any applicable government benefits to myself or to the party who accepts assignment.

SIGNED ________________________________ DATE ________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to Anne B. Parsons, Ph.D. for psychological services.

SIGNED ________________________________ DATE ________________________