# PRIVATE PRACTICE OF BEVERLY J JOHNSON MALP,PLLC

Client Information

Name_____ Date of Birth_____

Address_____City_____State_____

Zip_____ Sex _____ Marital Status _____ Social Security #_____

Employer _____ Occupation _____

Home Phone _____ Can Leave Message? Yes No

Work Phone _____ Can Leave Message? Yes No

Cell Phone _____ Can Leave Message? Yes No

Referred by _____

In Case of Emergency Notify _____

Relationship to you_____ Phone _____

Person Responsible for Account (if other than client)

Name_____ Date of Birth_____

Address_____City_____State_____

Zip_____ Social Security #_____Employer _____

Employer address _____

Home Phone _____ Can Leave Message? Yes No

Work Phone _____ Can Leave Message? Yes No

Cell Phone _____ Can Leave Message? Yes No

Relationship to client _____

Insurance Information

Primary Insurance company_____

Address_____

City_____State_____Zip_____

Phone _____ Policy/ID _____ Group # _____

Insured's name _____Relationship to you _____

*Please complete on back side*

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Secondary Insurance company_____

Address_____

City_____State_____Zip_____

Phone _____ Policy/ID _____ Group # _____

Insured's name _____Relationship to you _____

## Payment Policy/Assignment of Benefits and Authorization to Release Information

I understand that this office will bill my insurance company on my behalf, but I am fully responsible for all charges incurred. I guarantee payment of all charges, even those denied by my insurance carrier. I authorize the release of the minimum amount necessary of my personal health information to Mental Health Billing Professionals Inc. and to the above referenced insurance company, in order to obtain payment for services received here. I hereby instruct my insurance company to pay directly to Beverly J Johnson MALP, all benefits payable under my insurance policy.

_____ _____

Signature Date

FOR OFFICE USE ONLY:

Dx_____

Self Pay_____