KUMMERLE PSYCHOTHERAPY

PATIENT INFORMATION, BILLING INFORMATION, AND CONSENT FOR RELEASE OF INFORMATION

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PATIENT INFORMATION

Patient Name: _____

Birth Date: _____ - _____ - _____ SS#: ____ ____ ____ - ____ ___ - ____ ____ ____ Sex: __ M __ F

Address: _____ City/State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____Cell: (_____) _____ - _____

Primary Care Physician: _____ PCP Phone #: (_____) _____ - _____

Referral Source: _____

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BILLING INFORMATION:

Person Responsible for Bill:_____

Responsible Party Birth Date: _____ _____ Relationship to Patient:_____

Address (if different from above):_____

City/State: _____ Zip: _____ Home Phone: (_____) _____ - _____

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INSURANCE INFORMATION:

Insurance Company1: _____ Card Holder's Name: _____

Insurance ID#: _____ Account/Group #: _____

Insurance Company2: _____ Card Holder's Name: _____

Insurance ID#: _____ Account/Group #: _____

Assignment of Benefits and Release of Information

I have read all the information and have completed the above. I certify this information is true and correct to the best of my knowledge. I will notify provider of any changes in the above information. I hereby authorize my insurance benefits to be paid directly to provider and acknowledge that I am responsible for any balance, including for missed visits, not covered by those benefits. I authorize provider to release information requested concerning my care, to include psychiatric diagnosis and treatment, to insurers paying such benefits.

Patient's, or Guardian's signature_____ Date_____

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