TO S DATE: ______

UPDATED: ______ ______

______ ______

MAITLAND PSYCHOLOGY, P.A.

PATIENT INFORMATION

PATIENT'S NAME LAST | FIRST | M.I.

ADDRESS

CITY, STATE, ZIP

SOCIAL SECURITY NUMBER | HOME PHONE ( ) | WORK PHONE ( ) | CELL PHONE ( )

SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE | MARITAL STATUS

REFERRING PHYSICIAN | PHONE ( )

ADDRESS

PRIMARY CARE PHYSICIAN | PHONE ( )

ADDRESS

NAME OF: ☐ SPOUSE ☐ PARENT | DATE OF BIRTH

SOCIAL SECURITY # | WORK PHONE ( )

EMPLOYER

EMPLOYER ADDRESS

CITY, STATE, ZIP

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

ADDRESS

CITY, STATE, ZIP

RELATIONSHIP

PHONE ( ) | WORK PHONE ( )

PATIENT'S EMPLOYER | TELEPHONE ( )

EMPLOYER ADDRESS | CITY, STATE, ZIP

LEVEL OF EDUCATION | OCCUPATION

INSURANCE INFORMATION

PRIMARY CARRIER: NAME OF INSURANCE CO.

POLICY # | GROUP #

NAME OF INSURED | RELATIONSHIP

INSURANCE COMPANY ADDRESS

SECONDARY CARRIER: NAME OF INSURANCE CO.

POLICY # | GROUP #

NAME OF INSURED | RELATIONSHIP

INSURANCE COMPANY ADDRESS

IS THIS A WORKERS' COMP. CASE? ☐ NO ☐ YES IF *YES*, DATE OF INJURY:

IS THIS AN AUTO ACCIDENT? ☐ NO ☐ YES IF *YES*, DATE OF ACCIDENT:

OFFICE POLICY

Must be signed by all patients

I. RESPONSIBILITY FOR ACCOUNT - I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for professional services if the expense is not covered by my insurance policy.

II. COLLECTION INFORMATION - I understand that my portion of all fees are due at the time treated unless previous arrangements have been made. I will be billed for my portion of any fees unpaid at the time of service. Any amounts which are 60 days past due will be eligible to be turned over to a collection agency unless previous arrangements have been made. There will be a $20.00 charge for any returned check.

Signature - Patient ______________________________ Date ______________________

Responsible Party ______________________________ Relationship __________________

MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENT

III. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THIS ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE.

IV. RELEASE INFORMATION - I authorize any physician examining and/or treating me to release to any third party (such as in insurance company or governmental agency) any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment.

V. PHYSICIAN INSURANCE ASSIGNMENT - I authorize payment directly to any physician examining or treating me for surgical and/or medical benefits. Any service for which assignment is not accepted, are acknowledged to be my full and complete financial responsibility.

VI. RELEASE INFORMATION - I authorize Maitland Psychology, P.A. to release my medical records to any other healthcare providers involved in my continuing care and treatment.

Signature - Patient ______________________________ Date ______________________

Responsible Party ______________________________ Relationship __________________

Social Security # ____________________________