Psychology Consultants Associated

1205 York Road
Lutherville, Md. 21093
(410) 828-6062

REGISTRATION

Date _____ ***Appt Date/Time*** _____ ***Provider*** _____

PATIENT INFORMATION

_____
Last Name *First Name* *Middle Initial*

Address _____ Presenting Issues _____

City _____

Sex ❑ M ❑ F State _____ Zip _____

Birthday _____/_____/_____ Email: _____

Whom may we thank for referring you? ❑ Dr _____ Phone (_____) _____

❑ Hospital ❑Family ❑Friend ❑Website ❑Other

Emergency Contact and Phone Number (Required) _____

PRIMARY INSURANCE

_____
Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient _____ Birthday _____ Subscriber Soc. Sec. #_____

Address (if different from patient's) _____ Phone (_____) _____

_____ State _____ Zip_____

City _____

Insurance Company _____

Member ID # _____ Group #_____

ADDITIONAL INSURANCE

Is patient covered by additional insurance ❑Yes ❑ No

_____
Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient _____ Birthday _____ Subscriber Soc. Sec. #_____

Address (if different from patient's) _____ Phone (_____) _____

_____ State _____ Zip_____

City _____

Insurance Company _____

Member ID# _____ Group#_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Psychology Consultants all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient