psych care
associates, p.c.

Patient Information Form

Patient Name:_____ DOB:_____

Social Security:_____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____

Employer/School & Address:_____

Emergency Contact:_____ Relationship to pt:_____

Emergency Contact Phone:_____

Primary Care Physician:_____ Phone:_____

How did you hear about us?_____

I authorize Psych Care Associates, P.C. to release information necessary to process my insurance claim:

Date:_____ Signature:_____

Insurance Information:

Name:_____DOB:_____
Policy Holder Name:_____
Primary Insurance:_____ ID:_____
Secondary Insurance:_____ ID:_____
Name of Policy Holder Employer:_____
Address of Policy Holder Employer:_____
_____

Assignment of Benefits:

I request and authorize that payment of medical benefits in consideration to the attached claim be made directly to Psych Care Associates, P.C. by insurance carrier(s) as stated above. Further, I acknowledge responsibility for any deductible or coinsurance designated and/or not paid by insurer.

Date:_____ Signature_____