LCS

Associates in Psychological Services

Patient Information Sheet

PATIENT INFORMATION

Name: _____

Birth Date: _____ Age: _____ Male _____ Female _____

Address: _____

Apt # _____ City: _____ State: _____ Zip code: _____

Home Phone: _____ Mobile Phone: _____

Email address: _____ Marital Status: Single ____ Married ____ Other ____

INSURANCE INFORMATION

Name of insured: _____

Address: _____

Apt #_____ City: _____ State: _____ Zip code: _____

Home Phone _____

Relationship of patient to insured: Self ____ Spouse ____ Child ____ Other ____

Insured's Date of Birth: _____ Male _____ Female _____

Insured's Employer's Name or School Name: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

Insured's Policy # _____ Insured's Group # _____

Insurance Plan or Program Name _____

ALL PATIENTS TO READ AND SIGN: I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIM TO INSURANCE COMPANY(ies) and/or PHYSICIAN ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I HEREBY AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO THE HEALTH CARE PROVIDER. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALNCE. I PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THAT APPOINTMENTS MISSED OR CANCELLED WITHOUT 24 HOUR NOTICE WILL BE ASSESSED A "MISSED APPOINTMENT / CANCELLATION FEE" WHICH WOULD APPEAR ON MONTHLT PATIENT STATEMENTS AND IS NOT BILLABLE TO INSURANCE COMPANIES.

_____	_____	_____	_____
Patient's Signature	Date	Insured's Signature	Date

OFFICE USE ONLY

Referring Physicians: _____ UPIN _____ ICDS/DSM Diagnosis _____

Comments: _____

(DO NOT WRITE IN MARGINS)