Adult Contact Information

Date: ____/____/_____
Name : Last:_____ First:_____ MI____
Date of birth: ___/___/_____
Marital: ___single ___married ___Domestic partner ___divorced ___separated ___widowed
Race/Ethnicity ___Asian/Pacific Islander ___African American/black ___Native American
White/Caucasian ___Latino/Hispanic ___Decline to specify
Address: _____ City _____ State_____ Zip _____
Phone: home _____ work _____ cell _____

Email: _____

Responsible party (If other than above)

Name: Last_____ First:_____ MI____
Address:_____ City_____ State_____ Zip _____
Phone: home _____ work _____ cell _____

Emergency Contact

Name: Last _____ First: _____MI ____
Address: _____ City _____ State ____ Zip_____
Phone: _____ Relationship to client _____

Insurance

Name of company: _____
Address: _____

ID number _____
Group _____
Policy number: _____
Authoriztion: _____

Name of behavioral health company (may be different) _____
Address of behavioral health company _____
What is your co-pay amount _____
What is your deductible amount _____
How many sessions are authorized_____
Contact number for insurance _____

Policy holder information

Name: _____
Address: _____City _____ State_____ Zip_____
DOB : ____/____/_____
Work place name/ school name _____
Phone: Home_____ work _____ cell _____
Marital Status: _____
Relationship to client ____Self _____Child ____ Parent ____ Spouse

Name of client _____

Agreements and understandings:
(Please initial all)

1. I authorize the release of any medical or other information necessary to process my claim. _____
2. I also request payment of insurance benefits to either myself or the party who accepts assignment _____
3. I authorize payment of medical benefits to William Costas, Psy.D. for the services provided _____
4. I understand that I am responsible for all of my co-payments, deductibles and missed or cancelled appointment charges _____
5. I understand that I am responsible for providing correct and updated information necessary to bill the dates of service _____
6. In the event that the insurance does not cover the dates of service I understand that the balance is my responsibility. Up dated insurance information must be received within thirty (30) days of the date of service to bill properly _____
7. I understand tha if payment is not received within 180 days, my account may be submitted to a collections agency _____

Responsible party signature _____ Date _____

Witnessed :_____ Date _____