FAMILY PSYCHOLOGICAL RESOURCES

CONTACT INFORMATION FORM

The business office will need the following information to establish a client file. A copy of your insurance card will also need to be on file. Your signature will be required in order to file insurance claims.

PATIENT NAME__________________________ DATE OF BIRTH______________
ADDRESS:____
____
CITY_____________________________________ ZIPCODE:____________________
HOME TELEPHONE #_____________________
WORK TELEPHONE #_____________________
CELL TELEPHONE#______________________
EMAIL ADDRESS:____

RESPONSIBLE PARTY (If different from Patient): ________________________________
WORK TELEPHONE #____________________CELL TELEPHONE#__________________
EMAIL:____

PRIMARY CARE or Referring PHYSICIAN____
TELEPHONE #__________________________FAX # ______________________________
ADDRESS____
____
Would you like your Physician to be notified of your treatment at this clinic?
____Yes ____No Signature:_______________________________

EMERGENCY CONTACT PERSON:
Name________________________________ Relationship_____________________________
Telephone # ______________________

INSURANCE INFORMATION:
Policy Subscriber Name_____________________ DATE OF BIRTH:________________
Name of Insurance Carrier:________________________ Telephone #______________________
Policy #__________________________ SS#________________________________
Group #__________________________
Employer____(Tel)________________

Authorization to File insurance:__________________________________Date:________________
Policy Subscriber Signature

I authorize Dr. Wagner to provide psychological treatments. I understand that I am fully responsible for all costs related to my treatment. I understand that I am responsible for any costs incurred in efforts to collect any unpaid balance on my account. I have read and understand the HIPAA policy related to therapy and disclosure of information.

Client or Guardian________________________________ Date______________________