Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name (*First, M.I., Last):*

Date of Birth: Age: Sex: Male / Female Marital Status: S M W D

Address:

(Street) (City) (State) (ZIP)

Phone #: Social Security #: Driver's License #:

Employer: Work #: Cell #:

Employer's Address: Email address:

Referred By: If Student, School Name: Full / Part Time

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: Relationship to Patient:

Address:

Phone #: Social Security #: Driver's License #:

Employer: Work #:

Employer's Address: Email address:

Emergency Contact:

INSURANCE INFORMATION

Insurance Co.: Phone #:

Insurance Address:

Group #: Certificate or ID #:

Insured's Name: Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: Phone #:

Employer's Address:

Insured's Social Security #: Date of Birth: Sex: Male / Female

I hereby assign, transfer, and set over to Central Austin Psychology Group, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. An outstanding balance may be charged against a credit card on file. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. For no-shows and cancellations within 24 hours of your appointment time, a fee of $170.00 will be assessed.

Patient's Signature Date