

Adult

12/2025

PSYCHOLOGY HEALTH GROUP

A Group of Independent Practitioners

Family Physician _____ Referred by _____

Legal Full Name _____ Age _____ Birthdate ____/____/____

Preferred Name _____ Gender _____ SS# ____-____-____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Single ___ Married ___ Divorced ___ Legally Separated ___ Widowed _____

Work Full-Time ___ Work Part-Time ___ Unemployed ___ Retired ___ Full-Time Student ___ Part-Time Student ___

Employer _____ Occupation _____ Work Phone _____

Spouse/Partner/Significant other _____ Cell Phone _____

Employer _____ Occupation _____ Work Phone _____

Who may we contact in case of emergency or appointment change and cannot reach you?

Name _____ Relationship _____ Phone _____

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INSURANCE INFORMATION-Please complete in full. Insurance billing is a courtesy. It is important that we have all necessary insurance information in order to submit your claims correctly.

Primary Insurance or EAP _____ Policy Number _____ Group Number _____

Claims Address _____ Authorization# _____

Policy Holder _____ Policy Holder's Birthdate _____ Employer _____

Secondary Insurance _____ Policy Number _____ Group Number _____

Claims Address _____ Authorization# _____

Policy Holder _____ Policy Holder's Birthday _____ Employer _____

PATIENT RIGHTS AND RESPONSIBILITIES

I have reviewed Psychology Health Group's brochure which outlines policies with regard to patient rights and responsibilities. I acknowledge that I have been provided an opportunity to ask questions regarding this policy. **I agree to contact my insurance company to determine if authorization is needed.** I also understand that the patient or other responsible party is responsible for payment of fees unless otherwise agreed upon. I direct the insurer to pay, without equivocation, directly to Psychology Health Group all benefits due as a result of visits at Psychology Health Group. I further understand that I may be charged for any missed appointments or for appointments that are cancelled without sufficient notice. I also understand that failure to meet the financial obligations related to coming to the office may result in disruption of services and/or being turned over to a collection agency.

I give my consent to be treated at Psychology Health Group.

RELEASE OF INFORMATION

I authorize Psychology Health Group to release information necessary for billing only to my insurance company and/or financially responsible party. I authorize Psychology Health Group to release treatment plans necessary for authorization to my insurance company. **I also authorize Psychology Health Group to release information to the referring individual or organization and to my family physician.** I further acknowledge and authorize that my records may be anonymously reviewed by other members of Psychology Health Group for the purpose of treatment review and crisis management.

Signature _____ Date _____

Signature _____ Date _____