

Richard Born, Ph.D. LLC
Applied Psychological Health
•PATIENT INFORMATION•

Patient Name: _____ Gender: M F Date of Birth: _____

Address: _____
Street City State Zip Code

Billing Address if different from above:

_____ Street City State Zip Code

Social Security No: _____ Telephone: Home: _____

Marital Status: Single Work: _____

Married Cell: _____

Divorced

Is it OK to call and leave messages at these numbers? Yes No

Separated

Responsible party (if patient is a minor): _____

Widowed

Address (if different from above): _____

Employer/School: _____

Primary Care Physician: _____ Phone No.: _____

•PRIMARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone # for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

Authorization #: _____ for _____ sessions. Effective dates _____ to _____.

Medicare #: _____ Part B effective date: _____ Primary Secondary

Medicaid #: _____ Effective date(s): _____ Primary Secondary

Worker's Compensation Claim #: _____ Injury date: _____

•SECONDARY INSURANCE INFORMATION•

Policy Holder Name: _____ Gender: M F Date of Birth: _____

Policy Holder Address: _____
Street City State Zip Code

Telephone: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

INSURANCE COMPANY: _____ MENTAL HEALTH ADMINISTRATOR: _____

Address to send claims: _____ Phone no. for authorizations: _____

Phone No.: _____

Policy Holder's Social Security No.: _____ Policy #: _____ Group #: _____

The office of Richard Born, Ph.D. LLC will bill your insurance carrier directly for all services. Your signature expresses your agreement that the dates of service, services rendered, and the diagnosis will be provided with the insurance claim as necessary to process the claim. Your signature also indicates that you understand and agree that you are liable for payment of any services not covered by your insurance company.

Signature: _____ Date: _____

OFFICE USE:

Diagnosis:

Treatment Provider:

Financial Notes: