

Infinite Potential

Professional and Caring Psychological Services

PLEASE PROVIDE THE FOLLOWING INFORMATION

Today's Date: ____/____/____ The provider you are seeing: _____

Client's: Last name: _____ First: _____ MI: ____ SS#: _____-____-____

Address: _____ City: _____ State: ____ Zip: _____-____

Sex: **M F** Birth date: ____/____/____ Home Phone: (____) _____-____ Relation to Insured: _____

Mobile Phone: (____) _____-____

Status: Single Married Other
 Employed Unemployed Full-time Student Part-time Student

School or Employer: _____ Phone #: (____) _____-____

Address: _____ City: _____ State: ____ Zip: _____-____

Email Address: _____

Is the current concern primarily job related? **Yes** **No** Related to an accident? **Yes** **No**

Has prior professional help been received for this concern? **Yes** **No**

With Whom? _____ Phone: (____) _____-____

Client's Medications? _____ Physician: _____

Primary Physician: _____ Phone: (____) _____-____

Who referred you? _____ Phone: (____) _____-____

May I confirm this appointment with them? Yes No May I consult with them? Yes No

Signed _____ **Date** ____/____/____

Emergency Contact _____ Relation to Client _____ Phone: (____) _____-____

Primary Insurance Coverage:

Policyholder's Last Name _____ First _____ MI _____

Birth date: ____/____/____ Sex: **M F** Relation to Client _____

Insurance Company _____ Effective Date ____/____/____

Policy ID # _____ Group # _____ Referral # _____

Phone # to insurance company: (____) _____-____ Case Manager: _____

Secondary Insurance Coverage:

Policyholder's Last Name _____ First _____ MI _____

Birth date: ____/____/____ Sex: **M F** Relation to Client _____

Insurance Company _____ Effective Date ____/____/____

Policy ID # _____ Group # _____ Referral # _____

Phone # to insurance company: (____) _____-____ Case Manager: _____

PLEASE COMPLETE THE OTHER SIDE

If not provided above, please complete the following sections:

Father/Husband:

Last Name _____ First _____ MI _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Birth date: ___ / ___ / ___ Marital Status _____
SS#: _____ - _____ - _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Phone #: (_____) _____ - _____

Mother/Wife:

Last Name _____ First _____ MI _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Birth date: ___ / ___ / ___ Marital Status _____
SS#: _____ - _____ - _____
Employer: _____
Address: _____
City: _____ State: _____ Zip: _____ - _____
Phone #: (_____) _____ - _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is YOUR responsibility to pay any deductible amount, co-insurance, copay or any other balance not paid by your insurance company. This includes late cancellation fees (less than 24 hours notice) of \$60 and No Show fees of \$125 per occurrence. In order to control your cost of billings, we request that charges not covered by insurance or out of pocket expense for office visits be paid at the time services are rendered.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or psychological benefits that are rendered by my provider at Infinite Potential, including major medical benefits to which I am entitled, including MediCare, private insurance, and other health plans to Infinite Potential and it's representatives.

If this account is assigned to an attorney for collection and/or suit, I agree to pay your court cost and your attorney's fees. I agree that my unpaid account will accrue interest at a rate of 1 1/2% per month or 18% per year.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance including charges resulting from my failure to obtain preauthorization as may be required by my insurance carrier.

CLIENT'S NAME: _____

RESPONSIBLE PARTY:

SIGNATURE: _____ **DATE:** ___/___/___

SIGNATURE: _____ **DATE:** ___/___/___

For office use only:
Dx:
Copay
Deduct.