Lisa Blevins, PhD

Patient Information (please print) **Date:** _____________

Client's Name: _______________________________ Date of Birth: __________ Age:________ Gender ___

Address:____ City:________________ Zip:____________

Telephone: H: ______________________ W/Office: ____________________ Cell: __________________

Email:_________________________________ Emergency Contact Name/Number ____________________

Primary Insurance

Insurance Company Name: _____________________ Subscriber ID: ________________________________

Subscriber Name: _________________________ Ins Phone #: __________________ Group #____________

Subscriber Address (if different): ____

City: _____________________________________ State: ________________________ Zip: __________

Subscriber Date of Birth: _______________ Subscriber relationship to patient: ___________________

Secondary Insurance

Insurance Company Name: ________________________________ Insurance Company Phone: _________________________

Subscriber Name: ____Subscriber ID#: _______________ Group #_____________

Subscriber Address (if different): ____

City: ________________________________ State: ____________________________ Zip: _______________

Subscriber Date of Birth: _________________________ Subscriber relationship to patient: _____________________________

SIGNATURE ON FILE FOR THE RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

Insurance: *Your signature is required if you wish our office to be of service to you in billing your insurance company. Should we not receive this signed authorization, we cannot bill your insurance company for you and you will have to bill your insurance directly*. I understand that I am responsible for the deductible and non-covered services. I understand that my insurance policy may have certain limitations on mental health benefits. I agree to accept full responsibility for charges once these limitations have been reached. I further agree to accept full financial responsibility for payment of charges rendered to the above-named patient.

Release of Information: I authorize the release of any medical or other information necessary to process this claim.

Assignment of Benefits: I authorize payment of medical benefits from my insurance company for health services provided. I permit a copy of this authorization to be used in place of the original.

Client's Signature: ____________________________________ Date_______________

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