Psychological Solutions, LLC.

Patient & Insurance Information

Patient Information

Patient Name:

Patient SSN:

Patient Date of Birth:

Address:

City: State: Zip:

*Home Phone:

*Work Phone:

*Cell Phone:

Please Only List Numbers Where We Can Contact You Or Leave A Message.

Email Address:

Insurance Information

Insurance Company Name:

Name of Insured: Date of Birth:

Insured SSN: Group #:

Insurance ID # (if different than SS#):

Relationship to Insured:

Employer:

Did you obtain Authorization?: Authorization #:

Number of Visits Authorized:

Note: PleaseTurn Page Over and Sign Reverse Side.

Psychological Solutions, LLC.
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Affirmation of Understanding

I verify that the insurance information is correct as of the date below. I understand that if I do not provide accurate information or if my insurance company does not cover my services, I will be responsible for full payment of these mental health services. I authorize Psychological Solutions, LLC to file claims to my insurance company. I also authorize Psychological Solutions LLC to release medical information (e.g., diagnosis) necessary to process my claims. Finally, I authorize the insurance company to pay Psychological Solutions LLC directly for my services.

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Date Signature of Patient or Guardian of Minor