Patient Information Sheet-Confidential

Patient Name (Last, First, Middle): _____Gender_____

Address:_____ City_____State___Zip_____

Email Address_____ Social Security#_____

Date of Birth:_____ Age:_____ Nationality_____

Primary Phone Number: _____Secondary Phone Number: _____

Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Minor [ ]

Emergency Contact & Phone:_____

Referring Physician:_____ Phone_____ Fax_____

Custodial Parent's Name (if child is under age 18)*_____

If non-custodial parent, type of parental rights regarding psychological care*_____

*** A copy of Divorce papers or legal statement of psychological care is required before services can be rendered.**

Primary Insurance: _____ ID Number: _____ Group #_____

Responsible Party Name: _____Relationship_____

Social Security # _____ Date of Birth _____

Secondary Insurance: _____ ID Number: _____ Group #_____

Responsible Party Name: _____Relationship_____

Social Security # _____ Date of Birth _____

Medical Insurance Yes [ ] No [ ] **Please give insurance card to Receptionist**

Initial: ____ **IMPORTANT NOTICE**: Appointments must be canceled 24 hours in advance to avoid a **NO SHOW FEE** of **$87.50**. Furthermore, if you do not notify this office and do not show for your scheduled appointment, the no show fee will be applied and the remainder of your appointments will be canceled.

Initial: _____ **You are responsible for payment of all co-insurance, or, if you have no insurance coverage, payment of all charges to your account is due at the time of services rendered.**

Assignment of Benefits & Medical Release

I hereby authorize a direct payment to DFW Psychological for medical benefits, if any, otherwise payable to me under terms of my insurance plan. I hereby authorize DFW Psychological to release any information acquired in the course of my examination or treatment to my insurance company. I hereby authorize my physician, hospital, or medical facility to provide all information on my medical history and treatment to DFW Psychological. I hereby authorize photocopies of this form to be as valid as the original.

Signed: _____ (Patient's/Guardian's signature) Date: