Psychotherapy & Yoga Center

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Date _____ **Home Phone** _____ **Cell** _____

Patient _____
Last Name First Name

Responsible Party (if minor) _____

Street Address _____ **Email** _____

City _____ **State** _____ **Zip** _____

Sex ☐ **M** ☐ **F** **Age** _____ **Birth-date** _____ **Married** **Widowed** **Single** **Minor** **Divorced** **Partnered**

Employer/School _____

Occupation _____ **Buisness Phone** _____

Spouse (or responsible party) Name _____ **Birth-date** _____

Business Name and Address _____

Occupation _____ **Business Phone** _____

Who is responsible for this account? _____ **Relationship to Patient** _____

Social Security # _____ **Spouse's Social Security #** _____

Do you have Medical Insurance? ☐ **No** ☐ **Yes** **If yes,**

Name of Primary Insurer _____ **Policy Holder** _____

Subscriber # _____ **Group #** _____ **DOB** _____

Name of Secondary Insurer (if any) _____ **Policy Holder** _____

Subscriber # _____ **Group #** _____ **DOB** _____

☐ **Medicare** ☐ **Medicaid** **Claim ID#** _____

If Welfare, your number _____

In case of emergency, who should be notified? _____ **Phone** _____

How did you learn of our practice? _____

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with _____
Name of Insurance Company(ies)
and assign directly to Dr. _____ all insurance benefits, I any, otherwise payable services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, medigap benefits, be made either to me or on my behalf to _____ for any services furnished to me by that provider.
Name of Doctor

Signature _____ **Date** _____

Name (Please Print) _____ _____
Relationship to beneficiary