

MIND AND MOOD CLINIC

DATE: _____

PATIENT INFORMATION:

NAME: _____

BIRTHDATE _____ AGE _____ SS # _____ SEX _____

ADDRESS: _____

PHONE NUMBERS: _____

HOME _____

OCCUPATION _____

WORK _____

EMPLOYED BY _____

CELL _____

e-mail address: _____

May we e-mail our newsletter _____

INSURANCE INFORMATION:

PRIMARY INSURANCE:

SECONDARY INSURANCE:

Subscriber Name _____

Subscriber Name _____

Birthdate _____

Birthdate _____

Relationship to Patient _____

Relationship to Patient _____

Policy ID _____

Policy ID _____

Group # _____

Group # _____

Primary Physician's Name and Phone # _____

Who may we thank for referring you? _____

In case of emergency contact _____

I hereby consent to evaluation and treatment by _____

I authorize this provider to bill my insurance company for the services provided, and to release to my insurance company all information necessary to secure the payment of benefits.

I assign all insurance payments to be made directly to this provider and authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges not covered by my insurance.

Patient Signature _____

I acknowledge having received a copy of this office's *NOTICE OF PRIVACY PRACTICES FORM*

Date _____

Patient Signature _____

Witness _____