Germantown Private Psychiatry PLLC

THIS INFORMATION IS NEEDED TO FILE YOUR INSURANCE PLEASE PRINT CLEARLY

DATE: PATIENT SOCIAL SECURITY #

PATIENT LAST NAME PATIENT FIRST NAME MI

SEX:MALE/FEMALE BIRTHDAY AGE

PREFERRED NAME MARITAL STATUS

HOME
ADDRESS CITY/STATE/ZIP

HOME PHONE WORK PHONE CELL PHONE

EMPLOYER EMPLOYER ADDRESS

IN CASE OF EMERGENCY, WHO MAY WE CONTACT

PREFERRED PHARMACY NAME & TELEPHONE#

REFERRED BY WHOM OR HOW DID YOU HEAR OF US?

RESPONSIBLE PARTY

COMPLETE THIS SECTION IF YOU ARE LISTED AS A DEPENDENT ON SOMEONE ELSE'S INSURANCE

LAST NAME FIRST NAME MI

SSN# DATE OF BIRTH:

RELATIONSHIP TO PATIENT SEX:MALE / FEMALE

MARITAL STATUS

HOME ADDRESS CITY /STATE/ZIP

HOME PHONE WORK# CELL#

EMPLOYER EMPLOYER ADDRESS

INSURANCE INFORMATION

PLEASE PROVIDE WITH YOUR INSURANCE CARDS TO BE COPIED

Primary Insurance

INSURANCE COMPANY_____

NAME OF INSURED_____

POLICY #_____GROUP #_____

TELEPHONE NUMBER_____

DEDUCTIBLE_____COPAY_____

STREET ADDRESS FOR CLAIMS_____CITY /STATE/ZIP_____

IF YOU ARE A MEMBER OF A MANAGED CARE PLAN, PLEASE READ AND SIGN BELOW:

I HAVE CHECKED WITH MY INSURANCE COMPANY AND VERIFIED THAT THE PRACTITIONER I AM SEEING IS A PARTICIPATING PROVIDER ON MY INSURANCE PLAN. IF A REFERRAL FROM ANOTHER IS REQUIRED BEFORE SEEING THE OFFICE OF GERMANTOWN PRIVATE PSYCHIATRY PLLC, I AGREE THAT IT IS MY RESPONSIBILITY TO OBTAIN SUCH A REFERRAL. IF ANY CHARGE REMAINS UNPAID BECAUSE GERMANTOWN PRIVATE PSYCHIATRY PLLC DOES NOT PARTICIPATE IN MY PLAN OR BECAUSE I HAVE NOT OBTAINED A NECESSARY REFERRAL PRIOR TO TREATMENT,I AGREE TO BE PERSONALLY RESPONSIBLE FOR THE CHARGES.

__X_____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

SECONDARY INSURANCE

INSURANCE COMPANY_____

NAME OF INSURED_____

POLICY #_____GROUP #_____

TELEPHONE NUMBER_____

DEDUCTIBLE_____COPAY_____

STREET ADDRESS FOR CLAIMS_____

CITY/STATE/ZIP CODE_____