Psychological Services of Jacksonville, LLC

358 Stiles Avenue, Suite B Orange Park, FL 32073 Ph: 904-264-8311 Fax: 904-264-8377

CONFIDENTIAL PATIENT INFORMATION

PATIENT'S NAME	SSN	DOB	AGE	SEX: M / F

ADDRESS	CITY	STATE	ZIP

MARITAL STATUS SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐

HOME PHONE MAY WE LEAVE A MESSAGE AT THIS NUMBER? Y / N

BUSINESS PHONE MAY WE LEAVE A MESSAGE AT THIS NUMBER? Y / N

CELL PHONE MAY WE LEAVE A MESSAGE AT THIS NUMBER? Y / N

EMAIL

COMMUNICATION PREFERENCE: HOME ☐ BUSINESS ☐ CELL ☐ EMAIL ☐

EMERGENCY CONTACT	RELATIONSHIP	PHONE

ADDRESS	CITY	STATE	ZIP

NEXT OF KIN *(PARENT, LEGAL GUARDIAN, SPOUSE)*	RELATIONSHIP	PHONE

ADDRESS	CITY	STATE	ZIP

REFERRING PHYSICIAN	PHONE

INSURANCE INFORMATION

WILL METHOD OF PAYMENT BE SELF-PAY (*NON-INSURANCE COVERED*): Y / N

PRIMARY INSURANCE	ID #	RELATIONSHIP

PRIMARY INSURED NAME	DOB	PHONE

ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE	ID #	RELATIONSHIP

PRIMARY INSURED NAME	DOB	PHONE

ADDRESS	CITY	STATE	ZIP

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to Psychological Services of Jacksonville, LLC for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 11285B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Signature of Client or Guardian: _____ **Date:** _____

PLEASE BRIEFLY DESCRIBE MAIN CONCERN THAT HAS BROUGHT YOU HERE TODAY:

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