

INSURANCE INFORMATION

PATIENT INFORMATION

Patient's name: _____ **Patient's Birth Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: (_____) **O.K. to leave msg?** **Cell:** (_____) **O.K. to leave msg?**

Sex: M F **Patient's Relationship to Insured:** Self Spouse Child Other

Patient's Status: Single Married Other Employed Full-Time Student Part-Time Student

Patient's Employer Name or School Name: _____

Patient's Insurance Plan Name: _____

PRIMARY INSURANCE

Insured's Name (inc. middle initial): _____ **Insured's I.D. Number:** _____

Insured's Address (if different from patient): _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Cell Phone:** _____

Insured's Policy Group Number: _____ **Insured's Date of Birth:** _____

Insured's Sex: M F **Employer's Name (or School Name):** _____

Insurance Plan Name: _____

Secondary Insurance? Y N (if "Yes", please fill out information in "Secondary Insurance" section)

SECONDARY INSURANCE

Insured's Name (incl. middle initial): _____ **Insured's I.D. Number:** _____

Insured's Address (if different from patient): _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Cell Phone:** _____

Insured's Policy Group Number: _____ **Insured's Date of Birth:** _____

Insured's Sex: M F **Employer's Name (or School Name):** _____

Insurance Plan Name: _____

I authorize any insurance company to pay the proceeds of any benefits due me directly to the provider of record. I authorize the release of any medical, or other information necessary, to process an insurance claim. A copy of this agreement can be considered as an original for insurance purposes. If my insurance company requests information to be faxed, I understand that Leslie Hannon, Psy.D., LLC has no control over the confidentiality of the information.

Signature of Patient or Legal Guardian

Date