Spaulding Psychological Services, PLLC (SPS)

Patient Information: Date: _____

Name: _____ Phone: _____ Cell: _____
Last First Middle Initial

Address: _____
Street City State Zip

Patient SSN: _____ Sex: __M __F Date of Birth: _____Age: _____ Email: _____

Patient Status: __Minor __ Single __ Married __ Widowed __ Separated __ Divorced __ Partnered for ___ years

Patient Employer/School: _____Occupation/Grade: _____ __Full Time __ Part Time

Is condition related to: __Employment __Auto Accident __Other Accident?

Next of Kin: _____ Relationship: _____ Phone: _____

Address of Kin: _____
Street City State Zip

In case of emergency who should be notified? _____ Phone: _____

Primary Insurance Information: *(If the patient has West Virginia Medicaid, please provide the Medicaid Policy number* ***AND*** *the Managed HealthCare Company and Policy Number)*
Insurance Company/ WV Medicaid Managed Care Company Name: _____Ins. Phone: _____

Insurance Company Address: _____
Street City State Zip

ID #: _____Group #: _____ Phone # for Mental Health: _____

Name of Policy Holder: _____ Birthdate: _____ SSN: _____

Address of Policy Holder: _____
Street City State Zip

Employer: _____Relationship of Patient to Policy Holder: __Self __Spouse __Child __ Other _____

Additional West Virginia Medicaid Policy Number:_____ Group Number:_____

Secondary Insurance Information: Is patient covered by additional insurance? __Yes __No
Insurance Company/ WV Medicaid Managed Care Company Name: _____ Ins. Phone: _____

Insurance Company Address: _____
Street City State Zip

ID #: _____ Group #: _____ Phone # for Mental Health: _____

Name of Policy Holder: _____ Birthdate: _____ SSN: _____

Address of Policy Holder: _____
Street City State Zip

Employer: _____Relationship of Patient to Policy Holder: __Self __Spouse __Child __ Other_____
Other West Virginia Medicaid Policy Number:_____Group Number:_____

Turn Page Over

Contact Information and Permission:

I authorize: (Please indicate YES or NO for each option)

YES NO Leave a message on my home answering machine/voicemail

YES NO Leave a message on my work voicemail

YES NO Leave a message on my cell phone voicemail

YES NO Leave a message with a family member/friend at my home with no restrictions

YES NO Leave a message with all family members/friends at my home with only the following information:

YES NO Contact me/or insured by mail at the previously listed address (to include billing)

YES NO Contact me by email at previously listed email

Who should receive correspondence regarding billing: _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Spaulding Psychological Services, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finically responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

If Patient is Less than 18 Years Old:

Check legal custodian of child: __Parents __Sole Custody, Mother __Sole Custody, Father __ WV DHHR
Other/s (please specify)_____

If joint custody (decision-making) exists, both parents must consent to non-emergency medical/psychological care. Bring a copy of the divorce-parenting plan prior to the start of services.

Print name of each parent: _____ _____

Credit Card Authorization (optional):

Many clients find it convenient to charge sessions, deductibles, co-payments to a credit card on file. This information will be kept completely confidential.
Credit Card #,__MC __Visa __AE,__Disc_____ Expiration Date: _____ CV Code: _____

(Initial Here) _____ I authorize SPS to charge fees for services to this credit card.

Only for Parents of Teens/Young Adults: (Initial Here) _____ I authorize SPS to charge fees for services on behalf of my son or daughter, _____ to this credit card. __ MC __Visa __AE __Disc

Credit Card #: _____ Expiration Date: _____ CV Code: _____