

INFORMATION COLLECTION FORM

Patient Name: _____ Date: _____
Address: _____ City/State _____ Zip _____
Home Phone #: _____ Work Phone # _____ Cell# _____
Date of Birth: ___/___/___ Age: ___ SS#: _____ Sex: () Male () Female

Married () Divorced () Single () Separated () Widowed ()
Employed () Unemployed () Full-Time Student () Part-Time Student ()

Nearest relative NOT in home: _____ Phone #: _____

RESPONSIBLE PARTY : (other than insurance) if different from patient:

Name: _____ SS#: _____ Date of Birth ___/___/___
Address _____ City/State: _____ Zip _____
Home Phone #: _____ Work Phone #: _____ Cell/Mobile # _____

***** (Complete this Section ONLY If We Are to File Your Insurance) *****

If Workers Compensation accident-related: Date ___/___/___ Employ () Auto ()

Primary Insurance: _____ Policy Holder SS#: _____
Policy Holder DOB: ___/___/___ Policy Holders Name: _____
Policy Holder Employer: _____

Secondary Insurance: _____ Policy Holder SS#: _____
Policy Holder DOB: ___/___/___ Policy Holders Name: _____
Policy Holder Employer: _____

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I, the undersigned, hereby agree that, excluding Worker's Comp and Medicaid, I will guarantee payment of the bill for services rendered by the above-named doctor. I hereby authorize payment directly to same, of the benefits otherwise payable to me but not to exceed the doctor's regular charges for this service. I understand I am financially responsible to the doctor for charges not covered by this agreement, and I agree that the bill will be paid upon receipt of a statement unless other arrangements have been made with our office. I also understand that, should a collections process become necessary, I am responsible for all expenses connected with their process. I further authorize the release of information for insurance purposes.

Signed: _____ Referred by: _____