NEW PATIENT INFORMATION

Please print clearly and complete all information so your claim can be processed quickly and efficiently.

PATIENT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ Other	**DOB:**	**Age:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Patient Address: *(Street)* *(City)* *(State)* *(Zip)*			
		Patient Phone#:	
Social Security #:		**Driver's License #:**	
Employer:		**Work Phone #:**	
Work Address: *(Street)* *(City)* *(State)* *(Zip)*			
Primary Care Physician:		**Referred by:**	

PRIMARY INSURANCE INFORMATION

Insurance Co:		**Phone #:**	
Insured's Name: *(Last, First, M.I.)*		**Relationship to Insured:** (circle one) Self Spouse Dependent	
Insured's Employer:	☐ M ☐ F ☐ Other	**Work Phone#:**	
Insured's Date of Birth:		**Insured's Phone #:**	
Insured's Address: *(Street)* *(City)* *(State)* *(Zip)*			

SECONDARY INSURANCE INFORMATION

Insurance Co:		**Phone #:**	
Insured's Name: *(Last, First, M.I.)*		**Relationship to Insured:** (circle one) Self Spouse Dependent	
Insured's Employer:	☐ M ☐ F ☐ Other	**Work Phone#:**	
Insured's Date of Birth:		**Insured's Phone #:**	
Insured's Address: *(Street)* *(City)* *(State)* *(Zip)*			

RESPONSIBLE PARTY INFORMATION

Name: *(Last, First, M.I.)*		**Relationship to Patient:** (circle one) Self Spouse Dependent	
Home Address: *(Street)* *(City)* *(State)* *(Zip)*			
Phone #:		**Date of Birth:**	
Social Security #:		**Driver's License #:**	
Employer:	☐ M ☐ F ☐ Other	**Work Phone:**	
Work Address: *(Street)* *(City)* *(State)* *(Zip)*			

Did you obtain your insurance coverage through the Affordable Care Act (the Healthcare.gov website?) ***YES*** ___ ***NO*** ___ *If yes, please note that our office may not be participating (in-network) with some of the Affordable Healthcare Plans. I understand that my visit may not be covered by my ACA insurance and in the event that this is true, I will receive a bill for the balance due. If you would like your insurance coverage verified before the visit, please allow us time to do this before the doctor sees you.*

I hereby assign, transfer, and set over to Pamela Morris, Ph.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical or psychological information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____

Signature of Patient / Client / Legal Guardian Date

Pamela Morris, Ph.D. *Clinical Psychologist* *4971 East I-20 Service Rd. North, Willow Park, TX 76087*