Psychology Associates of Grand Rapids, P.C.
&
Independent Therapists

(Office Use Only)
Acct. #: _____
Provider: _____
DSM: _____

____/____/____
(Date)

Identifying Information:

Client Name: _____
(Last) (First) (Middle)

Parent's Name (if client is child): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: H: _____ W: _____ Cell: _____

___ No calls to home
___ No calls to office
___ No mail to home

∗ Accounts must be kept current or statements will be mailed & calls will be made.

Sex: M or F Date of Birth: ____/____/____

Employer: _____ Responsible Party Soc. Sec. #: _____

Referred by: _____

Insurance Information:

Insurance Co.: _____ Policy Holder's Name: _____

Claim's Address & Phone #: _____

Policy Holder's SSN #: _____ Policy #: _____ Group #: _____

∗ Policy Holder's Date of Birth: ____/____/____

Policy Holder's Employer: _____

Patient's Relationship to Policy Holder:
(Check one)
____ Self
____ Spouse
____ Child

In Case of Emergency Contact: Name: _____ Phone: _____

Relationship: _____

► **Attached to this sheet is additional information needed and the terms and policies of our services to you.**

AUTHORIZATION:

I authorize any holder of medical information about me to be released to any insurance carrier for the purpose of reimbursement. I authorize benefit payment to go directly to my therapist.

Signed: _____ **Date:** _____

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