Hollywood Psychology Center

954-981-8200 *tel* 954-381-5979 *fax*

Financial and Insurance Information

Today's Date

Patient Information

Name DOB Gender

Address

Marital status Social Security #

Phone # - home cell business

Employer Occupation

Address

Physician's name Phone #

Financially Responsible Person

☐ check if same as above

Name Social Security #

Address

Phone # - home cell business

Employer Occupation

Address

Referred by

Name Relationship Phone #

Address

Insurance Company Information

☐ Insurance ☐ EAP ☐ Self pay ☐ Other:

Company Name: Group#

Address Phone #

Insured's Name Policy#

Supplimental Insurance Comany Information

Company Name: Group#

Address Phone #

Insured's Name Policy#

Please note: All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. I understand that I am financially responsible for payment for services rendered to the above named patient. If I do not pay within 90 days, I understand my account will be remitted to collections and a collections fee will be added.

Signature of financially responsible person Date