COPAYMENTS ARE DUE AT THE TIME OF SERVICE

Billing Information
PLEASE COMPLETE AS FULLY AS POSSIBLE, Thank you.

For Office Use Only

Acct# _____

Dr# _____

Dx _____

_____

_____

_____

Date of 1st Session:

_____

Patient Name: _____
First Initial Last

Parent/Guardian (if patient is minor) _____
Date of Birth

Address: _____
Street Apt#

_____
City State Zip

Primary Phone: _____OK to call? _____

Secondary Phone: _____OK to call? _____ Email: _____

Patient Birthdate _____Age: _____

Female ☐
Male ☐

Single ☐ Married ☐ Widowed ☐ Separated ☐
Divorced ☐ Domestic Partner ☐

SSN: _____Employer: _____Occupation: _____

Work Phone: _____OK to call? _____

Primary Care Physician: _____Phone: _____

Referred By: _____Address: _____

I authorize River Valley Psychological Services to consult the referral and/or physician listed above: Yes__ No__ Initials__

Emergency Contact: _____Phone: _____

Address: _____Relationship to Patient: _____

Current Medications/Dosage:_____

Any Known Allergies? _____

INSURANCE INFORMATION REQUIRED

PRIMARY: _____ ID#: _____ Group#: _____
Name of Insured: _____ Birthdate: _____ Relation to Patient: _____
Work Phone: _____ Employer: _____

SECONDARY: _____ ID#: _____ Group#: _____
Name of Insured: _____ Birthdate: _____ Relation to Patient: _____
Work Phone: _____ Employer: _____

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY AND RELEASE OF INFORMATION

I hereby give my consent for psychiatric and psychological consultation and treatment. I agree to be financially responsible for cancelled appointments in accord with my doctor's cancellation policy. I authorize insurance benefits to be paid directly to the doctor, and that the doctor may release any information to the insurance company required for processing any claims.

THIS AUTHORIZATION WILL REMAIN IN EFFECT INDEFINITELY.

Patient Signature_____ Date_____

Signature of Parent/Guardian (if patient is minor) _____ Date_____