



Patient Information

Name: _____ Date: _____

Address: _____
Street City Zip Code

Home# _____ Work# _____ Cell # _____

Is it OK to leave a message at: Home? Y N Work? Y N Cell? Y N

Social Security# _____ Birth date: _____ Marital Status S / M / D / W Sex: M F

Emergency Contact: _____ Relationship: _____ Phone# _____

How were you referred? _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Subscriber ID: _____ Subscriber ID: _____

Subscriber's Name _____ Subscriber's Name _____

Relationship to Patient _____ Relationship to Patient _____

Subscriber SSN: _____ DOB: _____ Subscriber SSN: _____ DOB: _____

Employer: _____ Employer: _____

Insurance Phone# _____ Insurance Phone# _____

Office use only:

Effective Date _____ Effective Date _____

In or Out Network Deductible \$ _____ In or Out Network Deductible \$ _____

Percentage covered by Insurance _____ Percentage covered by Insurance _____

Co-pay Amount: _____ Visits per year _____ Co-pay Amount: _____ Visits per year _____

Is pre-certification required Y N If yes, contact name/number _____

Appointment Information

Reason for appointment: _____

The above information is true to the best of my knowledge. I authorize that all my insurance benefits be paid directly to Metropolitan Psychological Associates, P.C.. I understand that I am financially responsible for any balance whether or not paid by insurance. I also authorize Metropolitan Psychological Associates, P.C. or the insurance company to release any information required to process my claims. I authorize the use of this signature on all insurance submissions.

Responsible Party Relationship Date