Insurance Co. Information:

Primary Insurance : ___ Yes ___No
Name of Insured: _____
Employer of Insured: _____ Date of Birth of Insured: _____
Insurance Company Name: _____
Address: _____
Phone: _____
Policy Number: _____ Group Number _____
Patient Relation to Insured : Self_____ Spouse_____ Dependent_____ Other_____

Secondary Insurance : ___ Yes ___No
Name of Insured: _____
Employer of Insured: _____ Date of Birth of Insured: _____
Insurance Company Name: _____
Address: _____
Phone: _____
Policy Number: _____ Group Number _____
Patient Relation to Insured : Self_____ Spouse_____ Dependent_____ Other_____

Charges to Patient

$5.00 per page for correspondence
$20.00 Copying of chart
$80.00 for patients who No Show
or Do Not Give 24 Hour Notice
$25.00 Returned Check Charge
$15.00 Returned Phone Call
$3.00 Credit Card Processing Fee

Psychiatric Advance Directive

In the event that I, _____ have a psychiatric emergency and am incapable/incompetent to make a decision for myself regarding my psychiatric care, I designate the following person

Name: _____ Relationship to self_____
Address: _____
Phone Number: _____

Signature: _____ Date: _____