Hollywood Psychology Center

3595 Sheridan St., Suite 103, Hollywood, FL 33021
Tel: 954-981-8200 Fax: 954-272-8043
www.HollywoodPsychologyCenter.com

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 # DOB

Address

Phone # - home cell business

Employer Occupation

Address

Primary Insurance Information

(This information is required)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Employe ☐ Other:

Insurance Company: Name of Insured

Insured's Date of Birth Social Security # Sex ☐ M ☐ F

Policy# Group#

Secondary Insurance Information

(This information is required)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Employe ☐ Other:

Insurance Company: Name of Insured

Insured's Date of Birth Social Security Number Sex ☐ M ☐ F

Policy# Group#

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information in relation to all claims, including Medicare for benefits submitted on my behalf and/or my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each claim form to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed each claim.

I hereby authorize my insurance carrier to pay and assign all medical and/or mental health benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, Employee assistance Programs and other health plans to Hollywood Psychology Center. I authorize the release of any medical records for treatment, payment or healthcare operations.

Insurance is not a guarantee of payment for any claim, further I understand that I am financially responsible for all charges incurred regardless of insurance coverage.

Authorized Signature Date

All copays, co-insurances and deductibles must be paid at the time of service _____ (initial)

There is a full session charge for missed appointments without a 24 hour cancellation,

which cannot be billed to your insurance _____ (initial)