FOR OFFICE USE ONLY
Account #_____
Doctor #_____
DX_____
_____
_____
_____
_____
_____
_____

Date of first session

Billing Information
Please complete as fully as possible

Patient Name_____
First Initial Last

Address_____
Street Apt#

_____
City State Zip Code
Home Phone (____)_____OK to Call?_____
Work Phone (____)_____OK to Call?_____

Birthdate_____-____-____ Female__ Male__ Single__ Married__ Widowed__ Separated___
SSN_____ Employer_____ Occupation_____
Primary Care Doctor_____Phone (___)_____
Referred By_____ Address:_____ Phone (___)_____
I authorize River Valley Psychological Services to thank referral source above_____
Signature
Emergency Contact_____ Phone (___)_____
Address_____ Relationship_____
Current Medications_____
Any Known Allergies_____

IF ANOTHER PERSON IS RESPONSIBLE FOR CHARGES:
Name_____ Home Phone (___)_____
First Initial Last
Address_____ Work Phone (___)_____
Street Apt#
_____
City State Zip Code
PRIMARY INSURANCE_____ Subscriber_____
Group #_____ Identification #_____ Patient's relation to subscriber is:
Employer_____Self___Spouse___Child___Other_____
SECONDARY INSURANCE_____Subscriber_____
Group #_____ Identification #_____Patient's relation to subscriber is:
Employer_____Self___Spouse___Child___Other_____

TREATMENT CONSENT, FINANCIAL RESPONSIBILITY STATEMENT, 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.

Signature of patient_____ Date_____
If signed by another responsible person, specify relationship to patient.