

**Spectrum Psychological Associates, Inc.
Patient & Insurance Information**

PATIENT INFORMATION

Patient Name _____	
Patients S.S. # _____	Date of Birth _____
Address _____ City _____	
State _____ Zip _____	Home Phone # _____
Work Phone # _____	Cell Phone # _____
PLEASE ONLY LIST NUMBERS WHERE WE CAN CONTACT YOU OR LEAVE A MESSAGE	
E-Mail Address _____	

INSURANCE INFORMATION

Insurance company Name _____	
Name of Insured _____	Date of Birth _____
Insured's S.S. # _____	Group # _____
I.D. # (if different than S.S. #) _____	
Relationship to Insured _____	Employer _____
Did you obtain authorization? _____ Auth # _____ # visits _____	

I verify that the insurance information given is correct as of the date below. I understand that if I do not provide accurate information or if my insurance company does not cover my services, I will be responsible for full payment of these mental health services. I authorize Spectrum Psychological Associates, Inc. to file claims to my insurance company. I also authorize Spectrum Psychological Associates, Inc. to release medical information necessary to process my claims and authorize the insurance company to pay Spectrum psychological Associates, Inc. directly for my services.

_____ Date

_____ Signature of patient or guardian of minor