SALEM PSYCHOLOGICAL ASSOCIATES, P.A.
87 Stiles Road, Suite 106, Salem, New Hampshire 03079
603.893.7700 FAX 603.893.7331

NAME _____ AGE_____ DOB _____/_____/_____

ADDRESS _____ CITY, STATE, ZIP _____

CELL # _____ May we call or text this number? Y__ N__

HOME # _____ May we call this number? Y__ N__

WORK # _____ May we call this number? Y__ N__

EMAIL _____ May we contact you by email? Y__ N__

MARITAL STATUS_____ EMPLOYED BY _____ # OF HOURS_____

REFERRED BY_____ MY PHYSICIAN_____ PRACTICE NAME_____

KNOWN MEDICAL PROBLEMS _____

_____

CURRENT MEDICATIONS _____

_____

PERSON TO CONTACT IN AN EMERGENCY _____

PHONE # _____ RELATIONSHIP_____

INSURANCE INFORMATION

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

OMIT IF YOU HAVE INSURANCE CARD

INSURANCE COMPANY _____ PLAN (HMO, PPO, etc) _____

PATIENT'S ID # _____ GROUP # _____

IS PRE-AUTHORIZATION REQUIRED? **Y___ N___ DON'T KNOW___** AUTHORIZATION # _____

COPAY **$** _____ CURRENT INSURANCE DEDUCTIBLE AMOUNT **$** _____

SIGN ON REVERSE SIDE, PLEASE > > > > >

DO YOU HAVE SECONDARY INSURANCE? **Y___ N___ DON'T KNOW____**

POLICY HOLDER _____ RELATIONSHIP TO PATIENT _____

OMIT IF YOU HAVE INSURANCE CARD	INSURANCE COMPANY _____ PLAN (HMO, PPO, etc) _____ PATIENT'S ID # _____ GROUP # _____

Please sign both lines below

PATIENT'S (OR AUTHORIZED PERSON'S) SIGNATURE I authorize the release of any medical or insurance information necessary to process this claim. I also request payment of any applicable government benefits to myself or to the party that accepts assignment.

SIGNED **X** _____ DATE _____

PATIENT'S (OR AUTHORIZED PERSON'S) SIGNATURE I authorize payment of medical benefits to Salem Psychological Associates or to my clinician for psychological services.

SIGNED **X** _____ DATE _____