SALEM PSYCHOLOGICAL ASSOCIATES, P.A.

NAME OF CHILD _____ AGE _____ D.O.B _____

PARENT/GUARDIAN _____ PARENT/GUARDIAN _____

ADDRESS _____ ADDRESS _____

CITY, STATE, ZIP _____ CITY, STATE, ZIP _____

HOME PHONE _____ HOME PHONE _____

CELL PHONE _____ CELL PHONE _____

EMPLOYER/PH. # _____ EMPLOYER/ PH.# _____

MARITAL STATUS OF PARENTS/GUARDIANS _____

CUSTODY STATUS WITH CHILD _____

REFERRED BY _____

PEDIATRICIAN _____

SCHOOL/ GRADE _____

CURRENT MEDICATIONS _____

KNOWN MEDICAL PROBLEMS _____

INSURANCE INFORMATION

INSURANCE CO _____ TYPE OF PLAN (HMO, PPO) _____

INSURED PARTY _____ RELATIONSHIP TO PT _____

INSURED'S SS# _____ INSURED'S D.O.B. _____

INSURED'S EMPLOYER _____

PATIENT'S ID # _____ GROUP # _____

PRE-AUTHORIZATION REQUIRED? (CIRCLE) YES NO DON'T KNOW

AUTHORIZATION # _____ NUMBER OF SESSIONS _____

*SECONDARY INSURANCE CO.*_____

TYPE OF PLAN (HMO, PPO, ETC.)_____

INSURED PARTY:_____ RELATIONSHIP TO PT._____

INSURED'S SS#:_____ INSURED'S D.O.B.:_____

PATIENT'S ID #: _____ GROUP #: _____

PRE-AUTHORIZATION REQUIRED? (CIRCLE): YES NO DON'T KNOW

AUTHORIZATION #: _____ NO. OF SESSIONS: _____

INSURANCE CONSENT

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 who accepts assignment.

SIGNED _____ DATE _____

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

SIGNED _____ DATE _____