**5635 N. Scottsdale Rd., Scottsdale, AZ, 85250 Phone: (480) 261-4061 Fax: (480) 535-5548 Admin@IntuitivePsychologyPLC.com**

## ❑ Section 1: Patient Demographics

Required fields are in Bold print

**Patient Name**: ______________________ **Date of Birth** ____________ Nickname: __________

**Street Address** ______________________ **City** ____________ **State** ____ **Zip** __________

**Home Phone** ____________ **Mobile Phone** ____________ **Email**: ____________

**Gender**: ❑ Female ❑ Male **Marital Status**: ❑ Married ❑ Single ❑ Other **Patient Social Security** ____________

**Employment Status:** ❑ Full time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Disabled **Employer Name**: ____________

Employer Address ______________________ **Work Phone**: ____________

**Student Status**: ❑ Full Time ❑ Part Time ❑ Non-Student **If student, School Name**: ____________

Emergency Contact Person ____________ Relationship ____________ Phone ____________

**Referring Physician and/or PCP Name & Phone Number** ______________________

## ❑ Section 2: Primary Insurance Plan and Responsible Party Information (*for Blue Cross patient only*)

**Insurance Plan Name** ____________ **Mailing Address** ____________

**City** ____________ **State** _____ **Zip** ________ **Phone** ____________

**Policy or ID Number**: ____________ **Group #** ____________ **Effective Date**: ____________

**If the patient is NOT the Insured on the above listed plan, the following information MUST be completed**:

**Insured's Name** ____________ **Date of Birth** ____________ **Gender**: ❑ Female ❑ Male

**Insured's Social Security #** ____________ **Relationship to patient**: ❑ Spouse ❑ Parent ❑ Guardian ❑ Other

Address, <u>if different</u> than patient: ____________ City ____________ State _____ Zip ____________

**Home Phone** ____________ **Work Phone** ____________ **Employer Name**: ____________

## ❑ Authorization for Assignment & Release (All patients/guarantors must sign and date this section)

**I authorize my insurance benefits to be paid directly to the practice/doctor. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any out of network or non-covered services that may be provided. I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement. I agree to pay my required co-pay at the time of service and/or agree that I will pay in full for services rendered at the time of service.**

Patient/Guarantor Signature ______________________ Date ____________ Time ____________