PATIENT INFORMATION FORM
WELCOME TO HARBOR PSYCHOLOGICAL ASSOCIATES

LAST NAME	FIRST NAME	MI	
STREET ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS IF DIFFERENT	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	
MARITAL STATUS	GENDER	DRIVERS LICENSE #	
HOME PHONE	WORK PHONE	EMAIL ADDRESS	
EMPLOYER NAME AND ADDRESS		OCCUPATION	

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	MI	
STREET ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO PATIENT	PHONE		

INSURANCE INFORMATION

PRIMARY INSURANCE	INSURED NAME	PHONE	
INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH		GENDER
MAILING ADDRESS	CITY	STATE	ZIP

PLEASE PRESENT RECEPTIONIST WITH YOUR INSURANCE CARD

SECONDARY INSURANCE	INSURED NAME	PHONE	
INSURED SOCIAL SECURITY NUMBER	INSURED DATE OF BIRTH		GENDER
MAILING ADDRESS	CITY	STATE	ZIP

YOUR CO-PAY IS DUE AT THE TIME OF SERVICE. THANK YOU!

REASON FOR SEEING THERAPIST TODAY	
REFERRED BY	PHYSICIAN NAME AND ADDRESS

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Harbor Psychological Associates for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
_____ (Please Initial)

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care financing Administration or the intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature request that payment be made and authorizes releasing of the information to the insurer or agency shown. In Medicare/Other insurance company assigned cases, the therapist/supplier accept the charge determination of the Medicare/Other insurance company as the full charge (excluding non-contracted insurance) and the **patient is only responsible for the deductible, coinsurance, co-payment or non-covered services.**

Signature: _____ **Date _____**