Patient Information Form

Date:_____

Patient's Name:_____ Child/Adult (Please Circle)
Address:_____ City:_____
State:_____ Zip:_____ County: _____
Home Phone:_____ Work:_____ Cell:_____
Birth Date:_____ SS#:_____ Referring Person:_____

Person Responsible for Payment

Name:_____ Relationship:_____
Address:_____
Home Phone:_____ Work Phone:_____ Cell:_____
Credit Card Type:_____ CC#:_____ Exp:_____

Person to Notify in Case of Emergency

Name:_____ Relationship:_____
Address:_____
Home Phone:_____ Work:_____ Cell:_____

Employment Data

(If this is for your child, please provide information pertaining to the person insurance claims will be filed under)

Name of Company:_____
Address:_____
Occupation:_____ Do we have permission to contact you at your office?____

Primary Insurance

Name of Insured:_____ Relation to Insured:_____
Insured's birth date:_____ SS#:_____
Employer:_____ Insurance Co.:_____
ID#:_____ Group #:_____
Ins. Address:_____
Copay amount: _____

Signature on File Authorization

I hereby authorize payment of Medicare or other insurance benefits be made to my physical or supplier of any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to health financing administration, its agents, or other insurance carrier any and all information needed to determine these benefits or the benefits payable for related services. I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I will notify this office of any changes in my health status or changes in the information provided. If I am not in compliance with my plan's procedures I will be responsible for the total balance of my bill and authorize said charges against the credit card information provided on this form. I have read all the information on this form and answered all questions to the best of my knowledge.

Signature:_____ Date:_____

Patient's Signature(if minor)_____ Date:_____

**********For Office Use**********

DX:_____ Fee:_____ Copy of Ins. Card Obtained:_____
Code:_____ Checked:_____ Entered:_____

Barbara L. Costlow, LPC, NJ Lic. 00554