PSYCHOTHERAPY ASSOCIATES OF TAMPA BAY
BAYCARE OUTPATIENT CENTER
12780 RACE TRACK ROAD, SUITE 411
TAMPA, FL 33626-1395

OFFICE OF: ____________________

Last Name: ____________________ First Name: ____________________

Address: ____

City: ________________ State: ________________ Zip: ______________

Home Phone: ____________________ Cell Phone: ____________________

Date of Birth: ____________________ SS#: ____________________

Male: _____ Female: _____

Name of Insurance Carrier: ____

Primary Insured ID#: ____________________

Patient ID# (if different from above): ____________________ Group#: ___________

Insurance claims mailing address: ____

Insurance provider services phone#: ____________________

(Please provide copy of front and back of insurance card for billing)

Primary policy holder name (subscriber): ______________________________

Policy holder date of birth: ____

Relationship to patient: ____

Notes: