Psychotherapy Associates of Tampa Bay L.L.C.

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Social Security #: _____ Age: _____

Gender: □ Male □ Female □ Transgender Referred by: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Telephone #: _____ May we leave a message? □ Yes □ No

Alternate Telephone #: _____ May we leave a message? □ Yes □ No

*E-mail: _____May we email you? □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential means of communication.*

Occupation & Employer (if applicable): _____

INSURANCE INFORMATION

Insurance Company: _____ Identification #: _____

Check here if the information below is the same as the patient's information above: □

Policyholder's Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Social Security #: _____ Age: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Telephone #: _____ May we leave a message? □ Yes □ No

Alternate Telephone #: _____ May we leave a message? □ Yes □ No

I understand and agree that regardless of my insurance status, I am ultimately responsible for any balance on my account for professional services rendered. (For patients whose insurance carrier is a managed care plan, only the copayments and charges for non-covered services are due). I certify that the information provided above is accurate and true. I agree to notify my treatment provider of any changes made to my insurance information.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

I hereby authorize Psychotherapy Associates of Tampa Bay, L.L.C. to release any information pertaining to my treatment to my insurance company upon request and that insurance benefits may be assigned directly to Psychotherapy Associates of Tampa Bay, L.L.C.

_____ _____
Signature of Patient or Parent/Legal Guardian Date