



# PSYCHIATRIC ASSOCIATES

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[www.murphyclinic.com](http://www.murphyclinic.com)

Name \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Circle: Male Female  
 Home Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alternate Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Work Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Work Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **IF PATIENT IS A MINOR OR STUDENT PLEASE COMPLETE THE FOLLOWING**

Father \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Mother \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **RESEARCH**

Are you/your family interested in participating in our research studies? YES NO  
 If yes, may we contact you? YES NO  
 If yes, what is the best number to contact you? (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **ACKNOWLEDGEMENT OF RESPONSIBILITY**

This office will assist you in filing your claim to insurance, but takes no responsibility in payment delays or denials. The account is the responsibility of the patient or guardian. A CHARGE WILL BE ASSESSED FOR ANY APPOINTMENT NOT CANCELED WITHIN **24 BUSINESS HOURS**. I AUTHORIZE THE PROVIDER TO RELEASE TO MY INSURANCE CARRIER(S) AND THEIR BONA FIDE AGENT(S) SUCH INFORMATION AS MAY BE REQUIRED TO ADJUDICATE MY CLAIM. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER, AND I HEREBY ASSIGN AND SET OVER TO SUCH PROVIDER ALL OF SUCH BENEFITS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO THE PROVIDER FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_