PSYCHIATRIC ASSOCIATES

Foxhill Medical Building
4601 W. 109th Street, Suite 208
Overland Park, KS 66211
P (913) 438-8221 / F (913) 438-7709

Psychiatric Associates

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?(_____)_____-_____

INSURANCE INFORMATION

(may skip this section if able to provide card for copying)

PRIMARY CARRIER
Insurance Company_____
Claims Address_____
Name on Card_____
ID Number_____
Group Number_____

SECONDARY CARRIER
Insurance Company_____
Claims Address_____
Name on Card_____
ID Number_____
Group Number_____

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**_____