

**JOHN R DAY & ASSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES**

UPDATE PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

***PHONE:** _____ ***EMAIL:** _____

Policy Holder: _____ DOB: _____ Place of Employment: _____

Address (if different from patient): _____

Primary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Responsible Party: _____ Phone (if different from Patient): _____
(If patient is younger than 18 years old)

Billing Address (if different from patient): _____

(Please present one or both insurance cards to staff if you have not already done so)

Are you on one of these? Please check one. Sliding Fee: _____ Pro Bono: _____ If so, your account will be reviewed for the allowed number of visits.

[FOR OFFICE USE ONLY:

Effective Date: _____ Deductible: _____ Copay: _____ Coinsurance: _____

Authorization #: _____ Effective Date: _____

Contact Person: _____ Phone # _____]

If insurance precertification or preauthorization is required, John R Day & Associates may initially obtain it. However, it is ultimately the responsibility of the policy holder to ensure that any precertification or preauthorization has been completed and is kept current. **Please remember that authorization does not guarantee payment.** You are responsible for any deductibles, copays, coinsurance that are not covered by your insurance carrier. If you have any questions regarding these responsibilities, you may contact us.