JOHN R DAY & ASSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

UPDATE PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Address: _____

Policy Holder: _____ DOB: _____

Address (if different from patient): _____

Phone: _____ Place of Employment: _____

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

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

Responsible Party: _____ Phone (if different from Patient): _____

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 when the number of allotted sessions are completed.

[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.*** By signing below, you understand that you are responsible for any deductibles, copays, coinsurance that are not covered by your insurance carrier.

I have read and understand my responsibilities. If I have any questions regarding these responsibilities, I will contact Christian Psychological Associates.

_____ _____

Patient/Responsible Party Signature Date