

**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.