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.***
By signing below, you understand that 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.

_____ _____
Patient/Responsible Party Signature Date