CLAYTOR MEMORIAL CLINIC
1127 2nd Street, SW, Roanoke, VA 24016
Phone: 540-400-7495 Fax: 877-803-9136
10401 Warwick Blvd., Newport News, VA 23601
Phone: 757-782-2643 Fax: 877-803-9136
admin@claytorclinic.com
www.claytormemorialclinic.com

Outpatient Service Authorization and Permission to Treat

Patient's Name: (first, middle, last) _____

SSN _____ DOB: _____ Race: _____ Gender: M F

Marital Status: (circle one) Single Married Divorced Separated

Current Residence: (street, city, state, zip) _____

Home phone: _____ Cell phone: _____ Work phone: _____

May we leave a message at the telephone numbers listed above? (circle one) **Yes** **No**

Email address for reminders: _____

Parent/Guardian Name: _____ Relationship: _____

Address if not the same: _____

12 digit Virginia Medicaid:#: _____ Copay$_____
Circle one: Medicaid, Va Premier, Optima, Aetna, United Healthcare, Anthem, Molina ***Private/other:_____ ***Fill in below

Primary Private Insurance Co: _____ Customer Service Phone: _____
Mental/Behavioral Health Carrier:_____ Phone:_____
Policy Holder's Name::_____Relationship:_____
Policy Holder SSN :_____ Policy Holder's Date of Birth:_____

Address of Policy Holder (if different):_____
Insurance Claims Address:_____
Policy/ID#:_____ Group #:_____ Copay/CoInsurance $_____
Deductible info: _____
Prior Authorization info:_____

Secondary Private Insurance Co: _____ Customer Service Phone: _____
Mental/Behavioral Health Carrier:_____ Phone:_____
Policy Holder's Name::_____Relationship:_____
Policy Holder SSN :_____ Policy Holder's Date of Birth:_____

Address of Policy Holder (if different):_____
Insurance Claims Address:_____

Policy/ID#:_____ Group #:_____ Copay/Coinsurance $_____
Deductible info: _____
Prior Authorization info: _____

By signing below:

- I authorize the release of any medical or other information necessary to process my medical insurance claims. I authorize payment of medical benefits to Claytor Memorial Clinic. I understand that I will be responsible for any co-pay due to Claytor Memorial Clinic at the time of each session. I understand that I am fully responsible for any unpaid balance should the insurance carrier not reimburse CMC within 90 days of the invoice date.
- I hereby confirm that I am a custodial parent or legal guardian for the child named below and I authorize the provision of medical services for that child. I understand that services may include, but may not be limited to: a psychiatric assessment, referrals for counseling services, and prescriptions for medications. I am aware that nearly all medications carry the potential for unintended side effects. If my child is prescribed medications I understand that I have the right to be informed of the potential benefits and known potential side effects of such drugs and that Claytor Memorial Clinic medical staff will provide information about potential medication benefits and side effects to me.

Parental/guardian/authorized representative signature gives Claytor Memorial Clinic permission to treat myself/ the person listed above/my child and obtain emergency medical care while in our office.

_____ _____
Parent/guardian/authorized rep/foster parent/SW Date CMC Staff Signature