GRAHAM PSYCHOLOGICAL ASSOCIATES

Client Name (Last) _____ (First) _____ (Middle) _____Client date of birth_____

Client Address_____ City/State_____ Zip_____

Client Home Ph _____ Client Work Ph _____ Client Cell Ph_____

E-Mail address:_____ May we send your invoice by e-mail ___yes ___no

Can we leave messages at home? ___ work?___ cell?_____ Preferred Method of contact: Phone_____ E-mail_____

Client SS#_____ Education _____ Client Physician_____

Current Medications_____(type/amt)

Previous counseling/psychotherapy ____Yes ___No If yes, list counselor and dates_____

Who referred you to our office?_____ May we thank them for the referral? ____Yes ___No

Please check the following three statements:

1. Client Relationship to Insured: ___Self ____Spouse ____Child ____Other
2. Client Status: ___Single ____Married ____Other
3. Client Status: ___Employed ____Full Time Student ___Part Time Student

If billing insurance, please complete the following (subscriber information): (If worker's comp: Date of Injury: _____)

Insured's ID Number_____ Insured's Name (if different from client) Last_____ First_____

Insured's date of birth_____ Insured's Group Policy Number_____

Insured's Address_____City/State_____Zip_____

Employer's Name or School Name_____ Insurance Plan Name or Program Name_____

Customer Service Phone Number for Benefits, Eligibility, and Precertification_____

_____ City/State_____Zip_____

Responsible Party (if client is a minor):

Name_____ Relationship_____ Date of birth_____

Address_____City/State_____Zip_____

Home Phone _____ Work Phone _____ Emergency Contact Number _____

Can we leave messages at home?_____ or work?_____

I give this office permission to release any information obtained during treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to the practitioner (Bryan Ray, LPC, Andra Ray, LPC, Dr. Brandon Bates, Dr. Kerri Bates, and/or Dr. Barbara Hill) all rights, title and interest in the benefits payable for services rendered by practitioner, provided in the above mentioned policy of insurance. Said irrevocable assignment and transfer should be for the recovery on said policy of insurance, but shall not be construed to be an obligation of practitioner to pursue and such right of recovery provided. However, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier. I hereby authorize the insurance company herein listed above to pay directly to practitioner all benefits due under said policy by reason of services rendered therein. I will pay practitioner for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy.

A copy of the authorization shall be considered as effective and valid as the original. Signature below indicates agreement to all of the statements on this form.

_____ _____ _____

Client (or responsible party's) signature Printed Name Date