ARUN A. POL M.D., P.C.

Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.

PLEASE PRESENT A PHOTO ID AND INSURANCE CARD BEFORE SERVICES CAN BE RENDERED. PRINT LEGIBLY

1. PATIENT INFORMATION

Full Name (First, MI, LAST):_____

Gender:_____Marital Status: _____ Date of Birth: _____

Primary Mobile Phone:_____ Alternate Phone:_____

Social Security Number _____Email Address _____

Address: _____ City _____State ____ Zipcode_____

Pharmacy Name:_____ Pharmacy Phone: _____

Pharmacy Address: _____

2 RESPONSIBLE PARTY: (Legal Guardian if minor, who is primary on insurance)

Father's Name:_____ Date of Birth: _____

Mobile Phone: _____ Email address: _____

Address:_____City_____State____Zipcode_____

Mother's Name: _____ Date of Birth:_____

Mobile Phone: _____Email Address: _____

Address: _____City_____State____Zipcode_____

3. INSURANCE INFORMATION: We do not file secondary Insurance

Does patient have Insurance: ____ Yes _____No ____Self Pay (If not provider for your Insurance)

Primary Insurance: _____Phone # :_____

ID #: _____Group Number: _____

Policy Holder Name:_____ Relationship: __self __spouse __ child __other

Date of Birth of Insured:_____ Social Security of Insured:_____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical/psychological information necessary to process my Insurance claims. I authorize and request payment of medical benefits to my Psychiatrist, Arun A. Pol, M.D.,P.C. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. I understand and agree to pay for missed appointments not canceled with 24 or more hours of notice.

Signature of Patient (Guardian) _____ Date: _____