GRELLING PSYCHOLOGY ASSOCIATES
BARBARA GRELLING, PH.D.

PATIENT INFORMATION:

NAME: ________________________________ DATE OF BIRTH: _____/_____/______

ADDRESS: ____

CITY: ___________________________________ STATE _______ ZIP ____________

HOME PHONE: (_____) ________________ EMAIL: _____________________________

SSN: __________-__________-____________ SEX: ______ MALE _____ FEMALE

MEDICARE #: ___________________________

REFERRED BY: ____

SECONDARY INSURANCE COMPANY INFORMATION:

NAME: ____

CLAIMS ADDRESS: ____

CITY: ___________________________________ STATE _______ ZIP ____________

PHONE: (______) ______________________

POLICY #: ________________________________ GROUP #: _______________

INSURED'S NAME: ___________________________ DATE OF BIRTH: ____/____/____

Patient's Relationship to Insured: Self ____ Spouse ____ Dependent ____

INSURED'S SOCIAL SECURITY NUMBER: __________-__________-_____________

INSURED'S EMPLOYER: _______________________ STATUS: __ F/T __ P/T __ RETIRED

MEDICARE/MEDIGAP* ASSIGNMENT OF BENEFITS AND FINANCAL POLICY

MEDICARE/MEDIGAP* ONE TIME AUTHORIZATION FORM:

Beneficiary Name: ____

Medicare HIC #: ______________________________________

Medigap* Policy #: ____________________________________

I request that payment of authorized Medicare and/or Medigap* benefits be made to me or on my behalf to Grelling Psychology Associates or Barbara Grelling, Ph.D., licensed Clinical Psychologist, for any services furnished to me by this provider. I authorize holder of medical information about me to release to both:

1) the Centers for Medicare & Medicaid Services (CMS) and its agents, and

2) the Medigap* Insurer *(Name of Medigap* Insurer)* ____________________________________

any information needed to determine these benefits or the benefits payable for related services.

***NOTE: Your 'Medigap' policy is your Medicare supplemental insurance policy.**

FINANCIAL POLICY:

I understand that I must pay my copays at the time of service. I agree to pay for any charges that my insurance policy does not cover, including any charges for missed appointments, and for cancelled appointments that cannot be filled due to insufficient advance notice. I understand that cancelled and missed appointments must be paid in full.

(If you must cancel your appointment, please provide 24-hour advance notice.)

Beneficiary Signature: ____________________________________ Date: _________________