Psychological Associates, P.A. Updated Demographic Sheet 1/2021

Client's/Patient's Legal Name:				Date:
	First	Middle	Last	
Mailing Address:				
Street		City	State	Zip Code
Home Phone:		Cell Phone:		
E-mail Address:				
PRIMARY Insurance Company:		ID#		
Policy Holder/Insured:				
Insured's Date of Birth:		Insured's SSN:		
Insured's Relationship To Client/P	atient:			
SECONDARY Insurance Company:_			ID#	
Policy Holder/Insured:				
Insured's Date of Birth:		Insured's SSN:		
Insured's Relationship To Client/P	atient :			
	Insui	rance Authorization		
I hearby authorize Psychological Ass needed concerning treatment render request payment of insurance ben voluntarily given with understanding	ered to me that efits to be paid	is necessary to proces d directly to Psycholog	s an insurance clai	m. I also authorize and
Signature of Insured			Date	