Account No.: _____

Psychological Associates, P.A.

Updated Demographic Sheet 2026

Client's/Patient's Legal Name: _____ DOB: _____
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/Patient: _____

*SECONDARY Insurance Company:*_____*ID#*_____

Policy Holder/Insured: _____

Insured's Date of Birth: _____*Insured's SSN:* _____

Insured's Relationship To Client/Patient : _____

Insurance Authorization

I hearby authorize Psychological Associates, P.A. to release to my insurance carrier or its representative any information needed concerning treatment rendered to me that is necessary to process an insurance claim. I also authorize and request payment of insurance benefits to be paid directly to Psychological Associates, P.A. This authorization is voluntarily given with understanding and knowledge of purpose.

_____ _____
Signature of Insured Date