Center for Psychological Growth
Health~Wellbeing~Education

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Office Use:
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TherapyNotes
Date:

Patient Information Sheet

PLEASE PRINT DATE: ____________________________

Please complete the following form so we may establish your patient record. This form will be updated annually. Thank you for your help in keeping our records current. It helps us to serve you better.

Patient Name: Last: ______________________________ First: ______________________________ Middle Initial: _________

Address: ____ City ____

State: ____ Zip Code: ____

Best Number to Reach You: _____________________________ E-mail: ____

Date of Birth: ___________________________________ Social Security Number: ____________________________________

Gender: _______ Relationship Status: ____________ Student: Full Time___ Part time___ Race: ____________

Name of Insurance Company:____

Group Number:_____________________________________ID Number:____________________________ Effective Date:_________

HMO:___________________ PPO:______________________POS:________________ Authorization Required:___________________

Referring Physician:____ UPIN:___________________________________

Employer of Responsible Party: ______________________________ Address: ____

City: ____ State:________________________________ Zip Code:_________

Responsible Party: (if other than patient)

Name: Last: ______________________________ First: ______________________________Relationship to Patient: ______________

Address: ____City ____

State: ____Zip Code: ____

Home Phone Number: ___________________________________Work Phone Number: _______________________________________

Date of Birth of Insured: _________________________________Social Security Number: ____________________________________

Please indicate method of payment: Insurance _____ Cash: _____ Check: _____ Co-Pay Collected in Office: _____

I, the undersigned verify that I (or my dependent) have insurance coverage with _________________________________ and assign directly to **Dr. Howell/Gary Howell, Psy.D., PC and/or Dr. Scally/Melina Scally, Psy.D., LLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions.

Signature of Patient: ____ Date: ___________________________