Dr. Rebecca Kasper, PLLC

PATIENT INFORMATION **PLEASE PRINT CLEARLY.**

Last Name: **First Name:** **MI:** **Birth date:** **Age:**

Address: **City, ST, Zip** **SS#:**

Home Phone: **Cell Phone:** **Leave messages on** **Home Phone** **Cell Phone**

Male **Female** **Email:** **PRINT CLEARLY**

Employer: **Email appointment reminders and statements to the email address above. I can opt out at any time.** **Yes** **No**

Work Status – Circle One: **FT** **PT** **Retired** **Student** **Marital Status – Circle One:** **Single** **Married** **Separated** **Divorced** **Widowed**

RESPONSIBLE PARTY INFORMATION - IF YOU ARE THE RESPONSIBLE PARTY, MARK "SELF" AND MOVE DOWN TO "INSURANCE INFORMATION"

PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY: **SELF** **SPOUSE** **DEPENDENT**

GUARANTOR INFORMATION Please print clearly.

Last Name: **First Name:** **MI:** **Birth date:** **Male** **Female**

Address: **City, ST, Zip** **SS#:**

Home Phone: **Cell Phone:** **Work Phone:**

Email: **Marital Status – Circle One:** **Single** **Married** **Separated** **Divorced** **Widowed**

Employer: **Employer Add:**

Work Status – Circle One: **FT** **PT** **Retired** **Student**

*** * * * * IF PATIENT IS A MINOR * * * * ***

- Minor child is accompanied by: (Circle all that apply) **/ Mother / Father / Step-Mother / Step-Father / Legally Adopted Parent / Court Appointed Guardian**
- Child's biological parents are: (Circle one) **/ Married / Divorced / Legally Separated / Never Married**
- If parents are divorced does accompanying parent have: (Circle one) **/ Full Custody / Joint Custody**
- If Joint Custody, does accompanying parent have documentation from Court or written documentation giving permission from the other parent for counseling? (Circle One) **Yes / No** ***If NO please alert this office prior to counseling session.***

PRIMARY INSURANCE INFORMATION Please print clearly.

Carrier: **Auth #:**

Policy #: **Phone # from back of card:**

Policy Holder: **Birth date:** **Relationship to Patient – Circle One:** **Self** **Spouse** **Parent** **Other**

EAP / SECONDARY INSURANCE INFORMATION Please print clearly.

Carrier: **Type of Insurance – Circle One:** **EAP / Secondary** **Auth #:**

Policy #: **Phone # from back of card:**

Policy Holder: **Birth date:** **Relationship to Patient – Circle One:** **Self** **Spouse** **Parent** **Other**

ASSIGNMENT OF BENEFITS, RELEASE OF INFORMATION, PAYMENT AGREEMENT, HIPPA GUIDELINES

- I understand that payment is due at the time of service unless other arrangements have been made. I understand that Dr. Rebecca Kasper, PLLC will be billing my insurance carrier on my behalf. I understand that Dr. Rebecca Kasper, PLLC uses Medical Ancillary Services as the billing service.
- I agree to have the benefits from my insurance carrier assigned to Dr. Rebecca Kasper, PLLC.
- I understand Dr. Rebecca Kasper, PLLC will make a good effort to verify my insurance; however, I understand that I am responsible for knowing understanding my insurance benefits and eligiblility, and I am responsible for obtaining any and all authorizations necessary for my treatment.
- I permit Dr. Rebecca Kasper, PLLC to release any information deemed necessary to any insurance or third party, within the guidelines of HIPAA. (Health Insurance Portability & Accountability Act of 1996).
- I agree that I am responsible for full payment of this account and any court costs and attorney fees associated with the collection of this account.

Patient **Date**

Responsible Party if not Patient **Date**