METROPOLITAN
PSYCHOLOGICAL ASSOCIATES, P.C.

Patient Information

Name:_____ Date:_____

Address:_____
Street City Zip Code

Home# _____ Work#_____ Cell #_____

E-mail Address:_____

Is it OK to leave a message at: Home? Y N Work? Y N Cell? Y N Email? Y N

Social Security#_____Birth date: _____ Marital Status S / M / D / W Sex: M F

Emergency Contact:_____ Relationship:_____ Phone#_____

How were you referred?_____

Insurance Information

Primary Insurance_____ Secondary Insurance_____

Subscriber ID:_____ Subscriber ID:_____

Subscriber's Name_____ Subscriber's Name_____

Relationship to Patient_____ Relationship to Patient_____

Subscriber SSN:_____ DOB:_____ Subscriber SSN:_____ DOB:_____

Insurance Phone#_____ Insurance Phone#_____

Office use only:

Effective Date_____ Effective Date_____

☐ In or ☐ Out Network Deductible $_____ ☐ In or ☐ Out Network Deductible $_____

Percentage covered by Insurance_____ Percentage covered by Insurance_____

Co-pay Amount: _____ Visits per year_____ Co-pay Amount:_____ Visits per year_____

Is pre-certification required Y N If yes, contact name/number_____

Appointment Information

Reason for appointment: _____

The above information is true to the best of my knowledge. I authorize that all my insurance benefits be paid directly to Metropolitan Psychological Associates, PC. I understand that I am financially responsible for any balance whether or not paid by insurance. I also authorize Metropolitan Psychological Associates, PC. or the insurance company to release any information required to process my claims. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Relationship Date