Psychological Consultants of Marietta, P.C.
Ann Davis Roland, Ph.D., LMFT

PATIENT INFORMATION

Name_____DOB ____/____/____

Address_____SS#_____

City, State, Zip _____

Telephone Numbers: Home #_____Cell #_____

E-mail Address: _____

Your Employer_____Work # _____

Emergency Contact Person: _____

Home #:_____ Other #: _____

Do you give permission to contact you at the numbers above? ☐ Yes ☐ No

What telephone number(s) do you prefer to have messages left?

Home ☐ Cell ☐ Work ☐ E-mail ☐

To be compliant with HIPAA please list the email address that you wish for us to use to correspond with you. By listing your email address, you are providing your permission for us to correspond with you via this address.

Email: _____

Marital Status:

Single ☐ Married ☐ Spouse's Name _____ Separated ☐

Divorced ☐ Other ☐ _____

Who is your primary care physician? _____ _____

Referring Physician/ Person _____

Person Responsible for Bill: (or write " **Same**")

Name_____DOB_____

Address_____SS#_____

City, State, Zip _____

Employer:_____

Telephone Numbers: Home_____Work: _____

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*Primary Insurance Information:

(You will need to contact your insurance company for the following information)**

Insurance Company _____

Behavioral/Mental Health coverage provided by: _____

(This should be listed on the back of your insurance card)

Authorization number for this treatment: _____

Copay amount:$_____**Coinsurance percentage**(%): _____

Number of **allowed sessions** per year:_____ ☐ Calendar Year ☐ Fiscal Year

Name of Policy Holder_____DOB_____/_____/_____

Relationship to patient_____SS# _____

Billing Address (for **Behavioral Health Claims**)

_____

_____

_____

Phone# _____

Member ID#_____Group# _____

Secondary insurance coverage? ☐ Yes ☒ No

If Yes, Name:_____Phone #_____

Billing Address: _____

_____

_____

* Payment in full is expected at the time of services rendered. Arrangements can be made for my office to file on your behalf for insurance benefits. Clients offering such health insurance as complete or partial payment of their fees may do so by assigning anticipated insurance payments to Ann Davis Roland, Ph.D.,LMFT. If I am on your insurance panel, your contracted co-pay amount is required at the end of each session. **Each client is personally responsible for all charges and I accept no responsibility for services denied by insurance** . Most policies have limits on frequency of visits, and limit what services are covered. Please be sure you know your policy limitations, deductibles, and copays as it is not possible for me to know and monitor each client's specific insurance benefits. ** Insurance will not be accepted without this information being supplied.