# Billing Information

PAUL MYERS, Ph.D., LLC
LICENSED PSYCHOLOGIST

## Patient Information

*If financially responsible person is other than the patient, please complete page 2 of this form.*

Patient Name:

Date of Birth:

Gender:

◯ Male ◯ Female ◯ Other

Marital Status:

Address:

City:

ZIP:

Home Phone:

Work Phone:

Cellular:

Email:

Referred by:

## Insurance Information

*Please provide a copy of your insurance card(s), front and back.*

Primary Insurance Carrier:

Phone:

Claims Address:

City:

ZIP:

Name of Insured:

Relation to Patient:

Insured ID Number:

Group Number:

Insured Date of Birth:

Phone:

Employer:

Insured's Address:

City:

ZIP:

Secondary Insurance Carrier:

Phone:

Claims Address:

City:

ZIP:

Name of Insured:

Relation to Patient:

Insured's ID Number:

Group Number:

Insured's Date of Birth:

Phone:

Employer:

Insured's Address:

City:

ZIP:

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Paul Myers, Ph.D. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Paul Myers, Ph.D. I understand the financial policy established by Paul Myers, Ph.D. I understand that balances left unpaid over 60 days from the date of service may be assessed a rebilling/past due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Signature: _____ Date: _____

## Financially Responsible Person (Guarantor) *If other than patient*

Name:

Date of Birth:

Gender:

◯ Male ◯ Female ◯ Other

Relation to Patient:

Address:

City:

ZIP:

Home Phone:

Work Phone:

Cellular:

Email:

May messages be left for you: ◯ At home? ◯ At work? ◯ Cell? ◯ Email?

I hereby accept full financial responsibility for the patient outlined on this form. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Paul Myers, Ph.D. I understand the financial policy established by Paul Myers, Ph.D. I understand that balances left unpaid over 60 days from the date of service may be assessed a rebilling/past due account fee (minimum $5.00) per month and/or may be referred to a collection agency to facilitate payment.

Signature: _____ Date: _____