PATIENT INFORMATION

Stephen C. Meyers, M.A., L.C.P.C.

Patient Name: ______________________ Patient SS #: ______________________

Address: ______________________ Birth Date: ______________________

______________________ Insured Name: ______________________

(City) (State) (Zip)

Phone: (H) ______________________ Relationship to Patient: ______________________

(W) ______________________ Insured Employer: ______________________

(C) ______________________ :Code/Fee/Diagnosis

Insurance Company: ______________________ Phone #: ______________________

Subscriber #: ______________________ Group #: ______________________

Family Physician ______________________ Referred By: ______________________

Emergency Contact and Phone #: ______________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of the above provided information and any medical information necessary to: 1) provide for adequate professional coverage in the absence of the primary doctor; 2) to verify insurance coverage; and, 3) to file a claim for insurance benefits related to professional services rendered.

Patient Signature ______________________ Date ______________________

Responsible Party ______________________ Date ______________________

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I authorize direct payment of insurance benefits from ______________________ to Stephen C. Meyers, M.A., L.C.P.C. for Insurance Company professional services rendered.

Patient Signature ______________________ Date ______________________

FOR OFFICE USE ONLY

	In Network	Parity	Out of Network	Contact/Date: ______________________
DEDUCTIBLE	______	______	______	Mailing Address:
INSURANCE PAYS	______	______	______	______________________
COPAY/COINSURANCE	______	______	______	______________________
YEAR MAXIMUM	______	______	______	Payer #______________________
LIFETIME MAXIMUM	______	______	______	Pt. Notified ☐YES ☐NO

NETWORK______________________ ☐ IN ☐ OUT Dr. Notified ☐YES ☐NO

Precertification/Ongoing Cert Required? ☐ YES ☐ NO

MCO Name______________________ Phone #______________________ Contact______________________

Authorization #	Visits Auth'd	Date Range	CPT Code	Notes
______	______	______	______	______