PROFESSIONAL PSYCHOLOGICAL ASSOCIATES
CLIENT INFORMATION & AGREEMENT

Name _____ DOB/Age _____

SS# _____ Gender _____ Marital Status _____

Email _____ Ok to send an email? Yes No

Address _____ City _____ Zip _____

Cell Phone _____ OK to leave message? Yes No

Home Phone _____ OK to leave message? Yes N

Place of Employment / Phone _____

Person to contact in case of emergency (telephone/name) _____

School _____ Grade_____

Insurance Information

Name of Primary Insurance _____ Phone# _____

ID# _____ Group# _____

Cardholder's Name _____ DOB _____ SS# _____

Benefits Phone# _____ Insured's Place of Employment _____

At Professional Psychological Associates (PPA) we strive to provide you great service along with quality care. As a client of PPA, it is necessary for you to adhere to our policies and procedures. It is your responsibility to notify the office of any changes to your name, address, phone #, employment, and insurance. Your health insurance represents a contract between yourself and your insurance carrier. By signing this document you authorize PPA to furnish complete information regarding services rendered and to bill your insurance company. All fees for service have been explained. This document will remain in effect until revoked by you in writing. A photocopy of this assignment is to be considered as valid as an original. Please kindly provide 24 hours advance notice for a cancellation of appointment, if not, a graduated fee will be applied. I authorize PPA to release/exchange treatment information with my insurance carrier and/or insurance carrier utilization reviewers in order to facilitate my treatment by PPA. I understand that I am financially responsible for any balance or copaynot covered by my insurance.
I authorize payment of benefits to PPA.

_____ _____

Signature of Client, Parent or Guardian Date

_____ _____

Signature of Treating Therapist Date