WELCOME! - NEW PATIENT INFORMATION FORM
(NPI FORM) Date _____

If you want to use your **health insurance** to help with some of the cost of your treatment, it is very important that we have all of the following information from you immediately – or even mailed to us prior to your first appointment. Otherwise, please bring this form with you **already completed to the first consultation**. This can save you hundreds of dollars, so please help us to help you save money!

IMPORTANT PATIENT INFORMATION: (If you are requesting **marital therapy**, you can show one spouse as patient just for billing purposes on the first NPI form, and make a copy or get a 2nd form from your Dr later for the other spouse to complete for themselves. If you are the **parent of a child receiving treatment**, show your own information as parent on the front of the form, and there is a section on the back of the form to show information for the child.)

NAME (Please print or write clearly) _____

ADDRESS _____

_____ ZIP _____

HOME/CELL PHONE _____WORK PHONE _____

DATE OF BIRTH _____ MARITAL STATUS: S SEP M W D_____

GENDER M F SOCIAL SECURITY # _____

Were you referred to our office by your family doctor or primary care physician?
___ NO ___ YES
If yes, his or her full name/address/phone OR bring a copy of their business card for us to copy please?

_____
_____

EMPLOYER(S): (for yourself or your spouse, or both) _____

_____

_____

IS TREATMENT RELATED TO AN ACCIDENT? ___ NO IF YES, WAS IT AN ACCIDENT: ___ AT WORK ___ AUTO ACCIDENT ___ OTHER?

(over please)

YOUR INSURANCE INFORMATION: (OR be sure we have a photocopy of **BOTH** sides of your health insurance ID card(s) and ENLARGE when you photocopy the card so all numbers come out clearly!)
Insurance company name _____

_____

Policy # _____ Group # _____

If this insurance has not been in effect for more than 6 months, when did it become effective? _____
Who is the "insured" under the plan? (Usually this is the employee of the company that provides the insurance plan) _____
Their date of birth _____ Social Security # _____
Is this a "family plan" or just for one person? _____
Who is the "client/patient" (or the child) who is to receive treatment at The Psychology Center?
Name_____ Relationship to you? _____
Their date of birth _____ Their Social Security # _____
Their relationship to the "insured" person is:____ same person ___ spouse ____child ____step-child
Can you estimate the monthly cost of what you pay for this insurance plan? $_____
Does this plan require you to call the insurance co. for pre-authorization to receive treatment?
____yes ____ no ____ don't know
If yes, what tel# did you call?_____ On what date? _____
Were you given a pre-authorization #? _____ By whom? _____
For how many sessions?_____ What co-pay amount for each session? _____
If you receive an authorization letter in the mail from your insurance plan, BRING it in to give to the Dr!

If you have a **second** insurance plan: (Be sure we have a copy of **both** sides of this insurance ID card too)
Insurance company name _____

_____

Policy # _____ Group # _____
Who is the "insured" under the plan? _____
Who is the "client/patient" who is to receive treatment? _____
Their relationship to the "insured" person is:____ same person ___ spouse ____child
Who else is covered by this plan, whether they will be patients with us now or not? _____
Can you estimate the monthly cost of what you pay for this insurance plan? $_____

FOR DOCTOR'S **OFFICE** TO COMPLETE –
PROVIDERS: Dr. James Davenport, Psy. D. and/or Affiliated Staff Members at
The Psychology Center, Inc.

Diagnosis _____ DSM code _____

Charge per session _____ Signatures on file ____ yes ___ no Intake Dr.?(initials)_____

Date of 1st session _____ Date of 1st symptoms _____

FOR INTEGRATED HEALTHCARE BILLING SERVICE USE:
Information received on _____ 10/07