Susan M. Knell, Ph.D., LLC

Patient information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Contact numbers (please check preferred contact numbers)

Please only list contact information where I may contact you or leave a message

⇫ Home _____

⇫ Work _____

⇫ Cell _____ (If needed for scheduling, may I text you? Y N)

□Email _____ (If an invoice needs to be sent, may I send it to you electronically, via Email? Y N)

Insurance Information

Insurance Company Name _____

Name of Policyholder _____

Relationship to patient ⇫ Father ⇫ Mother ⇫ Guardian ⇫ Other

Address (if different from above): _____

_____

Date of Birth (policyholder) _____

Insurance ID # _____

Group # _____

Do you need an authorization? Y N If needed, Auth. # _____

I verify that the insurance information given is correct as of this date. I understand that if the information is inaccurate or if my insurance company does not cover my services, I am responsible for full payment of services. I authorize Susan M. Knell, Ph.D., LLC to file claims to my insurance company. I also authorize Susan M. Knell, Ph.D., LLC to release medical information necessary to process my claims and authorize the insurance company to pay Susan M. Knell, Ph.D., LLC directly for my services.

_____ _____

Date Signature of patient/Signature of parent or guardian of minor