Hope Psychological Services, P.C.
13295 Illinois St., Ste. 321
Carmel, IN 46032

Date: _____

Patient Information

Name:_____ Social Security Number:_____
Gender: ___ Male ___ Female Age: _____ Date of Birth: _____
Marital Status: ___ Married ___Separated ___Widowed ___ Divorced ___Single ___Cohabitating
Address:_____
City:_____ State: _____ Zip:_____
Home Phone:_____ OK to Leave a Message? ___Yes ___No
Cell Phone:_____OK to Leave a Message? ___Yes ___NO
Work Phone: _____ OK to Leave a Message? ___Yes ___No
Referral Source:_____
Emergency Contact Name and Phone Number:_____

Primary Insurance

Policy Holder Name: _____
Policy Holder Social Security Number: _____
Policy Holder's Relation to Patient: _____
Policy Holder's Address: _____
Policy Holder's Phone: _____ OK to Leave a Message? ___ Yes ___No
Policy Holder's Employer: _____
Insurance Company: _____
ID #: _____ Group/Contract #: _____

Secondary Insurance

Policy Holder Name: _____
Policy Holder Social Security Number: _____
Policy Holder's Relation to Patient: _____
Policy Holder's Address: _____
Policy Holder's Phone: _____ OK to Leave a Message? ___ Yes ___No
Policy Holder's Employer: _____
Insurance Company: _____
ID #: _____ Group/Contract #: _____

Assignment and Release

I certify that I, and/or my dependents, have insurance coverage with _____ (name/names of insurance company/companies) and assign directly to Hope Psychological Services and Dr. Linda Hinkle all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Hinkle may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment course is completed and paid in full.

_____ _____
Signature of Patient/Parent/Guardian Date

_____ _____
Printed Name of Patient/Parent/Guardian Relation to Patient