PTR

PSYCHOLOGICAL/THERAPEUTIC RESOURCES, LLC

P O. Box 777, New Bern, NC 28563
504 Pollock Street (252) 638-3881
210 Stonebridge Square, Havelock, NC (252) 447-4151

Today's Date:__________________

Client First Name:______________________________ MI:__________ Last Name:_______________________________

Date of Birth:____________________ Sex:_____________ Marital Status: ____________

Mailing Address:____ City:______________________________

State:________ Zip Code:_________ Telephone #:_________________________ Cell #:_________________________

Responsible Party Name and Social Security #: ____

Place of Employment____ Work #:___________________________

Emergency Name and #:____

All professional services rendered by Psychological/Therapeutic Resources, LLC are charged to the client. If you so request, insurance claims will be filed for you by our office at no additional charge.

I hereby authorize Psychological/Therapeutic Resources, LLC to file insurance claims for me and to furnish information to insurance companies concerning my illnesses and treatments and I hereby assign to the therapist all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I certify that the information contained herein is correct. A photocopy of this authorization and assignment shall be considered as valid as the original.

I have read the above information and provide consent for treatment.

Sign:____ Date:__________________________________

YOU MUST FILL OUT THE SECTION BELOW IN ORDER FOR INSURANCE TO BE FILED.

Name and Address of Primary Insurance Company:____

Insured's Name:____ DOB: _________________________

Insured's ID #:____ Group #:____

Patient Relationship to Insured:_____________________

Name and Address of Secondary Insurance Company:____

Insured's Name:____ DOB: ________________________

Insured's ID #:____ Group #:_____________________________

Patient Relationship to Insured:_____________________

DX:____