

Provider Name

**Okemos Psychological Services, LLC**

2172 Commons Pkwy Ste C  
Okemos, MI 48864-3986

*PATIENT INFORMATION*

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Communication Preferences: **Ok to leave phone message?** Yes  No  **Ok to text message?** Yes  No  **Ok to email** Yes  No

Gender as enrolled with insurance company \_\_\_\_\_ Female \_\_\_\_\_ Male Language Preference \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Preferred Pronouns \_\_\_\_\_

Race: \_\_\_Asian \_\_\_ American/Alaskan Indian \_\_\_ Black/African American \_\_\_ Hawaiian \_\_\_Other/Unk \_\_\_White \_\_\_Declined

Ethnicity: \_\_\_Hispanic / Latino \_\_\_Non Hispanic /Non Latino \_\_\_Declined

*GUARANTOR INFORMATION*

**LEGAL GUARDIAN, OR WHOMEVER BRINGS IN MINOR CHILD OR INCAPACITATED ADULT,  
MUST COMPLETE THIS SECTION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Communication Preferences: **Ok to leave phone message?** Yes  No  **Ok to text message?** Yes  No  **Ok to email** Yes  No

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Language Preference \_\_\_\_\_

**Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:**

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

**Patient OR Guarantor Signature** (if patient is a minor or incapacitated adult) \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**COPY OF INSURANCE CARD MUST BE ATTACHED**