Help Begins Here ...

Central Florida Counseling & Psychological Services, Inc
1514 W. Main St., Leesburg, Fl 34748
(phone)352-365-6506 (fax)352-365-6596

CONFIDENTIAL PATIENT INFORMATION – UPDATE 2021

(Please Print)

Name: _____
First Middle Last

Address: _____
Number Street City State Zip

Mailing Address (If Different): _____

Date of Birth _____ Phone #: ( )_____May we leave you a message: ◯Yes ◯No

Appointment Reminders – All appointment reminders will be sent via a text message to your cell phone.

Is it ok to send you appointment reminders? ◯Yes ◯No / Cell Phone #: ( ) _____

IMPORTANT NOTE: If you select No, then you are agreeing that you will take responsibility for creating your own appointment reminders.

e-Mail _____ May we contact you through email: ◯Yes ◯No

Has there been any changes to your insurance since your last visit? ◯Yes ◯No

IF YES, PLEASE PROVIDE NEW INSURANCE INFORMATION BELOW.
IF NO, JUST SIGN THIS FORM AND RETURN IT TO THE OFFICE.

Primary Insurance Carrier: _____Ins. Phone #:( )_____

Policy Holder Name: _____Date of Birth:_____ ◯Male ◯Female

Policy/ID Number: _____ Group Number: _____

Social Security # _____ Employer: _____

Relationship to patient: ◯Self ◯Other _____ Phone #:( )_____

Secondary Insurance Carrier: _____ Ins. Phone #:( )_____

Policy Holder Name:_____ Date of Birth_____

Policy/ID Number: _____ Group Number: _____

Social Security Number: _____ Employer: _____

Relationship to patient: ◯Self ◯Other _____ Phone #:( ) _____

RESPONSIBLE PARTY INFORMATION (if other than patient)

Name: _____ Check if: ◯Custodial Parent ◯Legal Guardian

Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____Cell Phone: ( ) _____

Relationship to Patient: _____e-Mail: _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process all claims. I authorize payment of medical benefits to: CM Reid & Associates, Inc./Central Florida Counseling & Psychological Services, Inc. Note: This form is for annual insurance verification / update only; all other signatures and authorizations obtained in the original intake form(s) remain in effect throughout the duration of treatment.

SIGNED: _____ DATE: _____

FOR OFFICE USE ONLY: Dx: _____

Click Button to Right to Reset Form