Adena Shoshan, Psy.D., P.C. **Today's Date: ______________________**

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: ____
(Last) (First) (Middle Initial)

Address: ____
(Street Name and #) (City) (Zip code)

Home Phone: (_____)__________________________ Date of Birth: ______________________

Marital Status: ______________________ Sex: ◻ Male ◻ Female

PCP Name: ______________________ PCP Phone: ______________________

INSURANCE INFORMATION

Who is responsible for co-pays, deductibles, non-covered services and other balances: (please check only one)

◻ Patient ◻ Other

Patient's Relationship to Guarantor/Policy Holder: ◻ Self ◻ Spouse ◻ Child ◻ Other

Policy Holder's Name (if other than self)____
(Last) (First) (Middle Initial)

Name of Insurance: ______________________ Policy Number: ______________________

Phone number on back of card: ______________________Policy Holder's Date of Birth: ______________________

If your insurance requires you to have an authorization/referral, have you requested this from your PCP: ◻ YES ◻ NO

Do you have a second insurance where claims should be submitted? ◻ YES ◻ NO

If yes, what is the name of the insurance: ______________________Policy #: ______________________

Phone number on back of card: ______________________ Policy holder's name: ______________________

Their relationship to you: ◻ spouse ◻ other: ______________________

In consideration of the provision of services to the above named patient rendered by Adena Shoshan, Psy.D. I agree to be obligated to pay any remaining balance due not covered by my/patient's insurance carrier(s). In addition, I authorize Adena Shoshan, Psy.D. to release to parties responsible for payment of my/patient's mental health service bill(s) such information as may be necessary for the completion of financial obligation. All such transactions will be undertaken under conditions of strict confidentiality. I agree to be held responsible for scheduled appointments canceled with less than 24 hours notice at a charge of $100.00 per occurrence, as this is not a billable charge to my insurance carrier.

____ ______________________
(Patient Signature) (Date)

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