

Mielke and Weeks Psychological Services

Patient Information

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____

Zip _____ Email _____ Soc Sec # xxx-xx- _____

Cell Phone _____ Home _____ Work _____

Employer _____

Address _____

Emergency Contact _____ Phone _____

Insurance Company _____

Subscriber ID # _____ Group # _____

Subscriber Name _____ Sub Birthdate _____

Authorization Phone Number (on back of card) _____

I was referred by: _____

friend or family physician google website other professional _____

Fee: _____

ICD-9 Dx: _____

I agree to begin the therapy process and agree that I will be responsible for fees for services not covered or paid by my insurance company. I understand that my personal information will remain confidential according to HIPAA requirements and will only be released with my written consent or as required by law.

Patient Signature

Date

Witness

Date