Mabel Lopez, Ph.D.
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Patient's Name (LAST, FIRST):	Sex M F	Birth Date: ____/____/_____ Age:	Marital Status: Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Street address, City, State, Zip and Email: _____ Email:		Home Phone: (__ __ __)__ __ __-__ __ __ __ Cell Phone: (__ __ __)__ __ __-__ __ __ __	Patient's Social Security# __ __ __ -__ __-__ __ __ __
Name of Person Financially responsible for this account:	Self Spouse Parent	Responsible Party's Birth Date: ____/____/_____	Responsible Party's Social Security # __ __ __ -__ __-__ __ __ __
Responsible Party's License Number: State:		Credit Card Type: [ ] MasterCard [ ] Visa [ ] Discover / Expiration date: ____/____/_____ Number: Name on Card: Verification Number (3 digits on the back of the card):	

Name of Employer:	Occupation:	Business Phone #: (__ __ __)__ __ __-__ __ __ __	Address:	How long at current employer?
Name of Spouse/ Parent:		Spouse/Parent Birth Date: ____/____/_____	Spouse/Parent Phone #: (__ __ __)__ __ __-__ __ __ __	Spouse/Parent Social Security __ __ __ -__ __-__ __ __ __
Reason for Visit:	Referred by: *(include address and phone#)*		How did you hear about us?	
Emergency contact:	Relationship to patient:		Phone# (s):(__ __ __)__ __ __-__ __ __ __	

Medicare Yes [ ] No [ ] / If yes, Medicare # Effective Date: ____/____/_____		*Medicaid Yes [ ] No [ ] / If yes, Medicaid # Effective Date: ____/____/_____ **Note, Medicaid does NOT cover mental health services.*	
Medicare Secondary Insurance Name	Address	Policy#	Group #

Worker's Compensation? [ ] Yes [ ] No Motor Vehicle Accident? [ ] Yes [ ] No If Yes, put W/V or MVA carrier below	Date of Accident: ____/____/_____	Treatment Authorized by:	Claim #	W/C or MVA Insurance Phone #
Primary Insurance Company Name:	Primary Insurance Policy #	Primary Insurance Group #	Subscriber name: Subscriber Birth Date: ____/____/_____	
Primary Insurance Company Address:	Primary Insurance Company Phone# (__ __ __)__ __ __-__ __ __ __		Is Insurance through your employer? [ ] yes [ ] No	
Secondary Insurance Company Name:	Secondary Insurance Policy #:	Secondary Insurance Group #		

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Mind and Brain Care for any services furnished to me by the physician/psychologist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient Signature:_____ Date Signed: ____/____/_____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize payment of medical benefits to Mind and Brain Care for any services furnished to me by the physician/psychologist. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administering claims of benefits.

Patient Signature:_____ Date Signed: ____/____/_____

Important: If the patient has a legal guardian, they are required to sign all forms, provide legal identification, and in circumstances other than a natural parent of a minor, provide legal guardianship documentation.