JAMES M. HICKEY, PSY. D.

PLEASE PRESENT YOUR INSURANCE CARD TO BE COPIED AT INITIAL VISIT

Client Name_____

Age_____ Date of Birth _____- _____-_____ Sex_____

Home Address_____

_____

City State Zip

Home Phone _____-_____-_____ Cell Phone _____-_____-_____

Work Phone_____-_____-_____

Email: _____

OK to leave phone message: y n Ok to text: y n Ok to email y n

Relationship Status (circle): Single Married Partnered Divorced Separated Widowed

Person Responsible for Payment: Self Father Mother Other

_____

Minors: Parents or Guardian's Names:_____/_____

Place of Employment_____

_____

Assignment of Benefits:

I hereby assign payment of authorized medical benefits and/or psychological benefits, to include major medical benefits to James Hickey, Psy. D. for any services furnished. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for charges whether or not paid by said insurance. If this account is assigned to an attorney for collection and/or suit, I will agree to pay your court cost and your attorney fees. I understand that all co-insurance and/or copayment fees (amount determined by my insurance carrier) are due at the time of service. I hereby authorize James Hickey, Psy. D. to release all information necessary to secure payment. I understand that insurance cannot be billed for missed appointments and that a 24 hour notice is required for canceling appointments or I will be charged a $35 fee.

Date:_____

Signature:_____