Timothy S Cahn, PhD, Inc **PATIENT INFORMATION**

Patient Name: _____ Sex: M ☐ F ☐

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date Of Birth**:** _____ SS**:** _____Employer: _____

Home Phone: (_____) _____ May we call this number? Y ☐ N ☐ Leave a message? Y ☐ N ☐

Cell Phone: (_____) _____ May we call this number? Y ☐ N ☐ Leave a message? Y ☐ N ☐

Email: _____ May we email? Y ☐ N ☐

Spouse/Partner: _____ Phone#: _____ May we release information? Y ☐ N ☐

Emergency Contact: _____ Phone#: _____ May we release information? Y ☐ N ☐

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PT NAME: _____

Billing Address with City/Zip Code: _____

Phone # Hm: _____ Wrk: _____ Relationship to patient: _____

Employer: _____SS#:_____

Signature: _____ Date: _____

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

Primary Insurance Company: _____

Subscriber Name: _____ Employer: _____

Relationship to patient: _____Male ☐ Female ☐ Subscriber date of birth: _____

Effective Date: _____ Group #: _____ ID #: _____

Secondary Insurance Company: _____

Subscriber Name: _____ Employer: _____

Relationship to patient: _____Male ☐ Female ☐ Subscriber date of birth: _____

Effective Date: _____ Group #: _____ ID #: _____

REFERRAL SOURCE

Name of referring physician or other source: _____

Name of primary care physician: _____

RELEASE/CONSENT

I hereby give my consent for psychiatric and/or medical consultation and treatment. I understand that Dr. Cahn is an independent practitioner and no other clinician is involved in the consultation and/or my treatment. I agree to be financially responsible for all charges for treatment and/or cancelled appointments as outlined in Dr. Cahn's financial policy. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits directly to Dr. Cahn.

Signature: _____Date: _____

Signature of Parent/Legal Guardian _____Date: _____

PRINT