PSYCHOLOGICAL SERVICE ASSOCIATES, INC.
3421 E. State Boulevard, Fort Wayne, IN 46805

NEW PATIENT INFORMATION FORM

Treating Clinician: ___Dr. Leib ____Dr. Dwyer ____Dr. Timbrook ____Ms. Gerow

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ___/___/____ Gender: __ M __ F
Last First MI

Address: _____
City State Zip Code

Telephone#: _____ _____ _____
(Home) (Work) (Cell)

If there is no answer, where may the office leave a brief message?

Answering machine/voicemail? YES ☐ NO ☐ With the person who answers the telephone? YES ☐ NO ☐

_____ At Home _____ At Work _____ On Cell (Please check all that apply)

Patient Social Security Number: _____ - _____ - _____ Employer Name: _____

Employer Address: _____
City State Zip

(Referring) Physician: _____ Physician Address: _____

In case of emergency, please contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Group Nbr: _____

Member ID: _____ Name of Subscriber: _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's Social Security Nbr: _____ — _____ — _____

Name of Subscriber's Employer: _____

Secondary Insurance Company: _____ Group Nbr: _____

Member ID: _____ Name of Subscriber: _____

Subscriber's Date of Birth: _____/_____/_____ Subscriber's Social Security Nbr: _____ — _____ — _____

Name of Subscriber's Employer:

FOR CHILDREN ONLY

Name of Father: _____ Name of Mother: _____

Address/Phone: _____ Address/Phone: _____

Child's School: _____ Last Grade Child Completed: _____

CONSENT FOR RELEASE OF INFORMATION

I hereby grant permission to Psychological Service Associates, Inc. to release and exchange information regarding (patient) _____ to/with _____

_____

Information to be released: ____Summary of treatment ____Complete Record _____Evaluation Results _____Other _____

For the purpose(s) of _____Coordination/continuity of care _____Other (please specify) _____

This consent is subject to revocation at any time by giving written notice to the guardian of records, except to the extent that action has been taken on reliance of this consent. Otherwise, this consent will expire: _____180 days following the termination of treatment, or _____ on _____/_____/_____

NOTE: A copy of this consent is valid as the original.

Signature_____ Date _____/_____/_____

Relationship to Patient (check one) ___Self ___Parent/Legal Guardian ___Other (please specify)_____

Witnessed By_____ Date _____/_____/_____