FAMILY PSYCHIATRIC SERVICES, LLC
Traci Marando, APRN
800 Village Walk, Suite 241
Guilford, CT. 06437-2762
(203) 747-5282 office • (203) 230-1102 fax
You must open this form directly in Adobe Acrobat Reader. Complete the form and save it again. Email the completed form, or fax to 203-250-9918 or 203-439-2087 Attention: Tanya

Name: _____ Date of Birth: _____

SS#: _____ ☐ M ☐ F ☐ single ☐ married ☐ widowed ☐ divorced

Address: _____Town:_____ State:_____Zip:_____

Phone: _____ Work: _____ Cell:_____

Primary Care Provider: _____ Referred By: _____

In an emergency, whom may we contact? Name:_____Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to patient: ☐ self ☐ spouse ☐ child ☐ other

Policy Holder's Employer: _____ ☐ full time ☐ part time

Secondary Insurance: _____ Effective Date:_____/_____/_____

ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to patient: ☐ self ☐ spouse ☐ child ☐ other

Policy Holder's Employer: _____ ☐ full time ☐ part time

ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize direct payment of surgical/medical benefits to the provider, for services rendered by the provider in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance company. Collection of any account balances past due three months after the billing date will be assigned to Eastern Account Systems of Connecticut, Inc.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the provider, to release any medical information necessary to process my claims and determine benefits payable. Physician's Billing Service will act as a secondary processor of claims/payments due on behalf of Family Psychiatric Services, LLC.

MEDICARE/MEDICAID I hereby authorize payment of Medicare benefits be made to the provider on my behalf for services rendered. I authorize the release of any medical information needed to determine benefits or the benefits payable for related services.

Patient Signature_____ Date _____