Mark A. Welch, D. O., Theresa Anderson, NP
Board Certified in Psychiatry
Board Certified in Sleep Medicine

PSYCHOLOGICAL AND PSYCHIATRIC SERVICES
aspen

Today's Date:_____

PATIENT

Name:_____ Referred by:_____

Home address:_____ City:_____ Zip:_____

Phone: Home #:_____ Work #:_____ Cell#:_____

Employers name & address:_____

Social Security #:_____ **Date of birth**:_____ Single / Married / Divorced

Driver's license #:_____ Name of nearest relative:_____

Nearest relative's address & phone #:_____

INSURANCE

Name of insured:_____ Relationship to patient:_____

Insured's social security #:_____ Insured's date of birth:_____

Insured's Employer:_____

Employer's address:_____ City:_____ Zip:_____

Insurance Company:_____ Phone #:_____

Insurance address:_____ City:_____ State:___ Zip:_____

Policy #:_____ Group #:_____

Is there secondary insurance? Y N If yes, ask for secondary insurance form.

AUTHORIZATION

I authorize use of this form on all my insurance claim submissions. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that I am responsible for my bill. I authorize Mark A. Welch, D.O. to act as my agent in helping me obtain payment from my insurance carrier(s). I irrevocably authorize payment of medical benefits directly to Mark A. Welch, D.O. for services rendered to me. I request payment of government benefits be made directly to Mark A. Welch, D.O., who hereby accepts such assignment.

I permit a copy of this authorization to be used in place of the original.

Date:_____ Signature:_____

Print Name:_____

DIAGNOSIS/COMMENTS

Diagnosis:_____ ICD-9 code:_____
Comments:

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