Marcia W. Hemley, Ph.D., P.C.
Demographic and Insurance Information

Proc. Code: _____
DX: _____
Date: _____

Last Name_____ First Name_____ MI_____

Street Address_____

Home Phone_____ May I leave a message for you at this number? Yes No

Cell Phone_____ May I leave a message for you at this number? Yes No

Work Phone _____ May I leave a message for you at this number? Yes No

Email _____ Social Security Number_____-_____-_____ DOB_____/_____/_____

Gender: M F Non-binary Marital Status: S M CU D W If Student: □ Full-Time □ Part-Time

Referred by: _____ Employer _____ Occupation _____

Emergency Contact: Name_____ Relationship_____ Phone _____

Person Responsible for Payment (if not patient): Name: _____Relationship:_____

Address:_____Phone:_____

Primary Insurance Company Information **This information is essential.**

Is This a Health Savings Account or Health Reimbursement Account? □ Yes □ No

Your relationship to the insured: SELF SPOUSE CHILD OTHER (specify)_____

Date of Birth of Insured: _____/_____/_____ Insured's Social Security Number _____-_____-_____

Insured's Name_____ Place of Employment of Insured_____

Insurance Company Name: _____ Insurance Company phone number _____

Insurance Billing Address:_____

Insured's ID Number:_____ Policy or Group Number: _____

Secondary Insurance Company Information (If Any) This information is also essential

Your relationship to the insured: SELF SPOUSE CHILD OTHER (specify) _____

Date of Birth of Insured: _____/_____/_____ Insured's Social Security Number _____-_____-_____

Insured's Name_____ Insurance Company Name _____

Insurance Billing Address_____

Insurance Company phone number _____

Insured's ID Number_____ Policy or Group Number_____

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits directly to Marcia W. Hemley, Ph.D. for services rendered.

Signature of Client or Guardian_____ Date_____