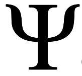

Clinical Psychology

John A. DeNinno, Ph.D.

1530 North 115th, Suite 307
Seattle, Washington 98133
Telephone: (206) 363-4205

Patient Name:_______________________________________Date:_________________

Address:____

City:_______________________State_____Zip:_________SS#:____________________

Telephone: Home_________________ Work_________________ Cell________________

Employer:________________________________ M/F (circle) BirthDate:_____________

Name of Spouse:___________________________ Referred by:______________________

Physician:_________________ Current Medications:_____________________________

In order to bill your insurance please complete the following. **All blanks** must be completed.

Primary Insurance Company:____

Address:____

Phone:___________________ Do You Need a Referral:_____ if Yes, do you have it?:_____

Policy # :________________________(include all Alpha Characters) Group#:___________

Subscriber Name:_________________________________ DOB:__________ M/F (circle)

Address:____ Apt#:_________

City:___________________________________ State:__________ Zip:______________

Telephone: Home_________________ Work_________________ Cell________________

Employer:______________________________ SS#:___________________________

Secondary Insurance Company:____

Address:____

Phone:___________________ Do You Need a Referral:_____ if Yes, do you have it?:_____

Policy # :________________________(include all Alpha Characters) Group#:___________

Subscriber Name:_________________________________ DOB:__________ M/F (circle)

Address:____ Apt#:_________

City:__________________________________ State:__________ Zip:_____________

Telephone: Home_________________ Work_________________ Cell_______________

Employer:______________________________ SS#:____________________________

Please indicate here if it is okay for the billing office to contact you if needed:______________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I further authorize the release of any medical records or other information necessary to process insurance. I authorize payment of medical benefits directly to John A. DeNinno, Ph.D.

I understand that a fee will be charged for appointments cancelled less than 24hrs in advance and for failed appointments. I understand that copays are due at the time of service.

Signature:____________________________________

Print Name:___________________________________