

**COLUMBUS PSYCHOLOGICAL ASSOCIATES**

**ADULT PATIENT UPDATE FORM**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SEX: M / F

HOME ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ SSN: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

HOW WOULD YOU LIKE YOUR APPT. REMINDER? TEXT / VOICE SPECIFY TELEPHONE.#: \_\_\_\_\_

PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

EMERGENCY CONTACT PHONE #: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**HAVE THERE BEEN ANY CHANGES TO YOUR INSURANCE? YES / NO**

**PRIMARY INSURANCE INFORMATION**

NAME OF PRIMARY INSURANCE: \_\_\_\_\_

POLICYHOLDER'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SSN: \_\_\_\_\_ POLICY/ID NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ INSURANCE PHONE #: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

NAME OF SECONDARY INSURANCE: \_\_\_\_\_

POLICYHOLDER'S FULL NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SSN: \_\_\_\_\_ POLICY/ID NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_ INSURANCE PHONE #: \_\_\_\_\_

I CONSENT TO TREATMENT, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO COLUMBUS PSYCHOLOGICAL ASSOCIATES.

I ACKNOWLEDGE I HAVE RECEIVED NOTICE OF COLUMBUS PSYCHOLOGICAL ASSOCIATES POLICIES AND PROCEDURES AND HIPAA NOTICE FORM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_