**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: _______________________