Brian Ross, LMFT

Date_____

Accept Assignment:_____Yes_____No

Dx:_____

Patient Information

Patient Name (Print)_____Date of Birth_____

Cell Phone:_____

Street Address_____Home Phone_____

Okay to Leave Message?____Yes____No

City_____State_____ZIP_____Work Phone_____

Okay to Leave Message?____Yes____No

Soc Sec#:_____Emergency Contact_____Emergency Phone_____

Sex: ____M ____F Age_____ Marital Status: ____Single ____Married ____Widowed ____Divorced ____Partnered

Employer_____Occupation_____E-Mail:_____

Referred by_____May we acknowledge this referral?_____

Primary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Policyholder's Date of Birth_____

Secondary Insurance Company_____Phone_____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID_____Group/Plan ID_____

Name of Policyholder_____Relationship_____

Address_____City_____State_____Zip_____

Soc Sec #_____Employer_____Policyholder's Date of Birth_____

Responsible Party

Name_____Relationship_____

Address_____Phone_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all necessary information to A.C.E. Billing, Inc, to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date