Joanna T. Koulianos, Ph.D. and Associates, Inc.
22 N. Florida Street Mobile, AL 36607
p: 251.300.2743 f: 251.217.9079

CHILD INFORMATION RELEASE TO INSURANCE

Family Physician_____ Referred by_____

Full Name_____ Age_____ Birthday ____/____/_____

Adddress_____City_____State_____Zip_____

Phone_____ Male___ Female___ School Attending_____ Grade_____

SS#_____-_____-_____ Mom's SS#_____-_____-_____ Dad's SS#_____-_____-_____

Mom's Name_____ Employer _____ Work Phone_____

Mom's Address _____ City_____ State_____ Zip_____

Dad's Name_____ Employer _____ Work Phone_____

Dad's Address _____ City_____ State_____ Zip_____

(If parents have different addresses, both parents will receive monthly statements.)

Who may we contact in case of emergency or appointment change and cannot reach you?

Name_____ Relationship_____ Phone_____
Name_____ Relationship_____ Phone_____

INSURANCE INFORMATION: Please complete in full. Insurance billing is a courtesy. It is important that we have all necessary insurance information in order to submit your claims correctly.

Primary Insurance_____ Policy Number_____ Group Number_____
Claims Address_____ Authorization #_____
Policy Holder _____ Policy Holder's Birthdate_____

Secondary Insurance_____ Policy Number_____ Group Number_____
Claims Address_____ Authorization #_____
Policy Holder _____ Policy Holder's Birthdate_____

PATIENT RIGHTS AND RESPONSIBILITIES

I have reviewed Joanna T. Koulianos, Ph.D. and Associates, Inc. policies with regard to patient rights and responsibilities. I acknowledge that I have been provided an opportunity to ask questions regarding this policy**. I agree to contact my insurance company to determine if authorization is needed.** I also understand that the patient or other responsible party is responsible for payment of fees unless otherwise agreed upon. I direct the insurer to pay, without equivocation, directly to Joanna T. Koulianos, Ph.D. and Associates, Inc. all benefits due as a result of visits at Joanna T. Koulianos, Ph.D. and Associates, Inc. I further understand that I may be charged for any missed appointments or for appointments that are cancelled without sufficient notice. I also understand that failure to meet the financial obligations related to coming to the office may result in disruption of services and/or being turned over to a collection agency.

I give my consent to be treated and become a patient at Joanna T. Koulianos, Ph.D. and Associates, Inc.

RELEASE OF INFORMATION

I authorize Joanna T. Koulianos, Ph.D. and Associates, Inc. to release information necessary for billing only to my insurance company and/or financially responsible party, I authorize Joanna T. Koulianos, Ph.D. and Associates, Inc. to release treatment plans necessary for authorization to my insurance company. **I also authorize Joanna T. Koulianos, Ph.D. and Associates, Inc. to release information to the referring individual or organization and to child's pediatrician/patient's family physician.** I further acknowledge and authorize that my records may be anonymously reviewed by other members of Joanna T. Koulianos, Ph.D. and Associates, Inc. for the purpose of treatment review and crisis management.

× Signature (Guardian) _____ Date_____