Kimberly Alfano, Ph.D., ABPP CN, RP

PATIENT INFORMATION/INTAKE

Patient Name		Cell Phone	Home Phone
Current Address	City	State	Zip Code
Date of Birth		e-mail address	
Employer	City	State	Occupation
Spouse's Name	Employer		Telephone Number

Who referred you to Dr Alfano? _____

INSURANCE INFORMATION

As a courtesy, my office can submit a claim to your insurance for you. It is your responsibility to be informed of your medical benefits. While many insurance companies have some form of coverage there are also HMO's and other plans that exclude this type of service.

I am a provider with **Medicare.**

Please fill out your insurance information and sign the authorizations, **ONLY if you would like our office to file an insurance claim for you.**

Insured Person's Name (parent/policyholder)	Telephone Number	
Relationship to patient	e-mail address	
Permanent or Insured address	State	Zip Code
Insurance Company Name	ID Number	Group #
Telephone Number	Claims Address	

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Alfano to release information required to process my insurance claims.

Patient/Guardian Signature	Date

ASSIGNMENT: I authorize payment of medical benefits directly to the provider by my insurance company for diagnostic and treatment services.

Patient/Guardian Signature Date

OFFICE USE

Dx: _____ FEE: _____ DIS: _____
CPT : _____ CO-PAY: _____