FAMILY PSYCHOLOGICAL SERVICES
of Lakeland

# PATIENT INFORMATION SHEET

**There are two pages to this form, please remember to complete both.**

We use email as a way to communicate various information between the patient and the office. Please list the best email address to use for this purpose: _____.

Family Psychological Services of Lakeland, LLC uses reasonable means to protect the security and confidentiality of emails we send and/or receive, however, we cannot guarantee the security and confidentiality of the information sent through. Family Psychological Services of Lakeland, LLC cannot be held liable for any breaches of confidentiality caused by the patient or any third party when using this system, as well as, any improper disclosure of confidential information that is not caused by intentional misconduct. This information is only used by Family Psychological Services of Lakeland, LLC and is governed by the same HIPPA protection as all other patient information.

| LAST NAME | FIRST NAME | MIDDLE INITIAL | PATIENT'S NICKNAME |
|---|---|---|---|
| | | | |

| DATE OF BIRTH | PATIENT'S GENDER – CIRCLE ONE | PATIENT'S MARITAL STATUS – CIRCLE ONE |
|---|---|---|
| | FEMALE MALE | SINGLE MARRIED OTHER |

| PATIENT'S EMPLOYMENT STATS – CIRCLE ONE | PATIENT REFERRED BY – IF REFERRED BY A DOCTOR – NAME & PHONE NUMBER |
|---|---|
| EMPLOYED STUDENT OTHER | |

| PATIENT'S MAILING ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

**PARENT'S NAME – IF PATIENT IS A MINOR**

| MOTHER | FATHER |
|---|---|
| | |

**CHILD LIVES WITH – CIRCLE THE ONES THAT APPLY**

MOTHER FATHER STEP-MOTHER STEP-FATHER LEGAL GUARDIAN OTHER:

## APPOINTMENT REMINDERS

**PLEASE CHECK HOW YOU WOULD LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS; PLEASE READ YOUR OPTIONS BELOW AND CHOOSE THE ONE THAT YOU WISH FOR.**

| ☐ TEXT MESSAGE (REQUIRES CELL PHONE NUMBER & CARRIER) | ☐ EMAIL (REQUIRES EMAIL ADDRESS) | ☐ PHONE CALL (CALL WILL BE MADE TO THE NUMBER LISTED IN THE HOME PHONE LINE) |
|---|---|---|

## PHONE & EMAIL

| HOME PHONE NUMBER | CELL PHONE NUMBER | WORK PHONE NUMBER & EXTENSION |
|---|---|---|
| | | |

**EMAIL ADDRESS – WE NEED TO KNOW IN-ORDER TO RECEIVE EMAIL REMINDERS**

## APPOINTMENT REMINDER DISCLAIMER & CONSENT FORM

Family Psychological Services of Lakeland, LLC will be utilizing a system that engages in Text Messaging, Email, and Automated Phone Calls for Appointment Reminders and other patient care related information. Patients may choose to change the method of how they receive their appointment reminder or other patient information at any time by speaking with a member of the office staff. Family Psychological Services of Lakeland, LLC uses reasonable means to protect the security and confidentiality of texts and emails we send and/or receive, however, we cannot guarantee the security and confidentiality of the information sent through email and texting. Family Psychological Services of Lakeland, LLC cannot be held liable for any breaches of confidentiality caused by the patient or any third party when using this system, as well as, any improper disclosure of confidential information that is not caused by intentional misconduct. This information is only used by Family Psychological Services of Lakeland, LLC and is governed by the same HIPPA protection as all other patient information. ** **Please Note** – that if you need to cancel or reschedule an appointment after you receive your appointment reminder; you would need to call the office at 863-606-6001 and speak to the receptionist**. I have read and understand the above information and agree to the terms set forth.

_____ _____

Signature of Patient or Parent/Legal Guardian | Printed Name of Patient or Parent/Legal Guardian

_____ _____

Relationship to Patient | Date

## PRIMARY INSURANCE (POLICY INFORMATION)

| PRIMARY INSURANCE COMPANY NAME | | CUSTOMER SERVICE PHONE NUMBER | |
|---|---|---|---|
| ID/MEMBER NUMBER | GROUP NUMBER | EFFECTIVE DATE | |
| PATIENT'S RELATIONSHIP TO INSURED – CIRCLE ONE<br>SELF SPOUSE CHILD OTHER | INSURED'S NAME – LAST NAME, FIRST NAME, MI | INSURED'S DATE OF BIRTH | |
| INSURED'S STREET ADDRESS | INSURED'S CITY | INSURED'S STATE | INSURED'S ZIP |
| INSURED'S GENDER – CIRCLE ONE<br>FEMALE MALE | INSURED'S EMPLOYER | | |

## SECONDARY INSURANCE (POLICY INFORMATION)

| SECONDARY INSURANCE COMPANY NAME | | CUSTOMER SERVICE PHONE NUMBER | |
|---|---|---|---|
| ID/MEMBER NUMBER | GROUP NUMBER | EFFECTIVE DATE | |
| PATIENT'S RELATIONSHIP TO INSURED – CIRCLE ONE<br>SELF SPOUSE CHILD OTHER | INSURED'S NAME – LAST NAME, FIRST NAME, MI | INSURED'S DATE OF BIRTH | |
| INSURED'S STREET ADDRESS | INSURED'S CITY | INSURED'S STATE | INSURED'S ZIP |
| INSURED'S GENDER – CIRCLE ONE<br>FEMALE MALE | INSURED'S EMPLOYER | | |

**INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. You agree to pay any portion of the charges not covered by insurance.**

*** If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company. Authorization received by your insurance company is **NOT** a guarantee of payment.***

**Note that you are ultimately responsible for all fees incurred, excluding our negotiated provider discounts with insurance companies with whom we are a participating provider.**

**INSURANCE AUTHORIZATION:** I authorize any holder of medical or other information about me to release information as needed to my insurance company, the Social Security Administration and Health Care Financing Administration, or its intermediaries, carriers, or billing agent of Family Psychological Services of Lakeland, LLC, in order to process the claims. I permit a copy of this authorization to be used in place of the original. I request payment of the medical insurance benefits either to myself or to the party who accepts assignment.

I am responsible for any fees or services not covered by Aetna, Blue Cross Blue Shield, or any other insurance plan.

_____ _____

Signature of Patient or Parent/Legal Guardian | Printed Name of Patient or Parent/Legal Guardian

_____ _____

Relationship to Patient | Date