PATIENT DATA SHEET

Important – Please notify us of any changes to your personal information i.e., home address, phone numbers, insurance information.

DATE_____(Staff only)MR#_____

NAME_____DATE OF BIRTH_____AGE___
ADDRESS_____
CITY_____STATE____ZIPCODE_____
SOCIALSECURITY#_____MARITAL STATUS_____
HOMEPHONE_____CELL PHONE_____
EMPLOYER_____SPOUSEEMPLOYER_____
EMPLOYER'S ADDRESS_____
NAME OF RESPONSIBLE PARTY(if other than client)_____
RESPONSIBLE PARTY SOCIAL SECURITY#_____
RESPONSIBLE PARTY PHONE#_____

INSURANCE INFORMATION
TRICARE INSURANCE/SPONSOR SSN _____
MEDICAID ID#_____

Fees

Our initial fees range from $145.00 to $225.00, generally less after the first visit. Fees vary with the type of service and which provider you are seen by. The fee schedule represent existing normal and customary rates in this area. Please feel free to discuss these matters with your individual provider and/or our office staff.

Consent to Treatment

I give my written consent for treatment at Eastern Carolina Psychiatric Services Center.

Authorization to Release Information

I hereby authorize ECPS to release to my insurance company full information including copies of records relative to my treatment.

Assignment of Benefits-Office Services & Hospital Services

I hereby request payment of authorized benefits be made either to me for services paid in full or on my behalf for services not paid in full to ECPS for any services furnished to me by ECPS.

Appointments

Appointments are scheduled in advance to provide the optimum time for each patient's individual treatment needs. If you are unable to keep you appointment, please inform the office 24 hours prior to the scheduled time or a $25.00 charge will be added to your account.

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SIGNATURE OF PATIENT DATE SIGNATURE OF ADDITIONAL RESPONSIBLE PARTY