Valdosta Psychiatric Associates, LLC

Male ☐
Female ☐ **Patient Name**:_____
First Middle Last

Date of Birth_____ **Social Security Number**_____ **Marital Status**_____

Street Address_____
City State Zip Code

Home Phone_____ **Cell Phone** _____

Employer_____ **Work Phone** _____

Email Address

If Patient is a minor, do you have legal custody? If divorced, has either parent had parental rights terminated?

Legal Guardian's Name_____ Relationship to Patient_____

Legal Guardian's Social Security Number_____ Guardian's Date of Birth_____

Is Patient a Full-Time Student? Yes ☐ No ☐ School_____

****** A Parent or Legal Guardian must accompany minor children when seeing the physician. Medication WILL NOT be dispensed without a parent or legal guardian present. Legal Guardians will be asked to provide proof of Guardianship******

Emergency Contact_____ **Phone**_____

Emergency Contact Address_____

Relationship to Patient

Insurance Company_____ **Policy Holder Name:**_____
(Name as it appears on the insurance card)
Insurance Address_____ **Phone**_____

Policy/Subscriber Number_____ **Group Number:**_____

Policy Holder SSN: **Policy Holder Date of Birth:**

I request that payment and benefits be made on my behalf to Valdosta Psychiatric Associates, LLC for any services furnished to me by its physicians or providers. I understand that my signature also authorizes release, if necessary, of any medical, HIV, psychiatric and substance abuse information contained in my records to my insurance or its assignees. I request and authorize treatment at Valdosta Psychiatric Associates, LLC. I understand I am responsible for any deductible, co-payment or any amount not covered by my insurance. I understand that Valdosta Psychiatric Associates LLC turns delinquent accounts over to a third party collector, and I will be responsible for the physician fees, plus a $50.00 collection fee. Monthly finance charges may be added to all accounts over 60 days old. A fee of $30.00 (thirty) dollars will be charged for any returned checks.

_____ _____
Signature of Patient or Legal Guardian (Relationship) Date