

**KRISTINA HOUSER, PH.D.**  
**BILLING INTAKE INFORMATION FORM**

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE NUMBER: WORK: \_\_\_\_\_ HOME: \_\_\_\_\_  
SOCIAL SECURITY NUMBE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ARE YOU EMPLOYED? YES: \_\_\_\_\_ NO: \_\_\_\_\_  
IF YES, NAME AND ADDRESS OF YOUR EMPLOYER: \_\_\_\_\_

DO YOU HAVE INSURANCE COVERAGE? YES: \_\_\_\_\_ NO: \_\_\_\_\_  
IF YES, NAME AND ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_

NAME OF POLICYHODER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
IDENTIFICATION NUMBER: \_\_\_\_\_

ARE YOU COVERED BY A SECOND INSURANCE COMPANY? YES: \_\_\_\_\_ NO: \_\_\_\_\_  
IF YES, NAME AND ADDRESS OF SECONDARY INSURANCE COMPAY: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_  
IDENTIFICATION NUMBER: \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE? \_\_\_\_\_

IN ORDER TO SECURE PAYMENT FOR MY TREATMENT THROUGH MY INSURANCE COMPANY, I AUTHORIZE **KRISTINA HOUSER, PH.D.** TO COOPERATE WITH MY INSURANCE COMPANY'S CLAIMS AND MANAGED CARE PROCEDURES, INCLUDING RELEASING SUFFICIENT CLINICAL INFORMATION (FOR EXAMPLE, DIAGNOSIS, SYMPTOMS, AND TREATMENT PLANS) TO ANSWER THEIR SPECIFIC QUESTIONS. I UNDERSTAND THE INSURANCE/MANAGED CARE COMPANY IS OBLIGATED TO MAINTAIN THIS INFORMATION CONFIDENTIALLY. I AUTHORIZE THE AFOREMENTIONED INSURANCE COMPANY TO MAKE PAYMENT DIRECTLY TO **KRISTINA HOUSER, PH.D.** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE AND THAT THE ENTIRE BILL IS MY RESPONSIBILITY REGARDLESS OF MY INSURANCE COVERAGE.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_

(If patient is under 18 years old)