JANE Z. WOODROW, PH.D.
BILLING INTAKE INFORMATION

PATIENT'S NAME: ______________________________ TODAY'S DATE: ____________

ADDRESS: ________________________ CITY: __________ STATE: __ ZIP: __________

TELEPHONE NUMBER: (WORK): ________________ HOME): ____________________

SOCIAL SECURITY NUMBER: ________________ 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, DO YOU WISH TO USE YOUR INSURANCE? YES: _____ NO: _____

IF YES, NAME OF INSURANCE COMPANY: ______________________________
ADDRESS OF INSURANCE COMPANY: ______________________________

NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: ______________

RELATIONSHIP TO PATIENT: ______________ GROUP NUMBER: ________________

IDENTIFICATION OR SOCIAL SECURITY NUMBER OF POLICYHOLDER: ______________

DO YOU HAVE A SECONDARY INSURANCE POLICY? YES: ______ NO: ________
IF YES, NAME AND ADDRESS OF YOUR SECONDARY INSURANCE COMPANY: ___________
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NAME OF POLICYHOLDER: ______________________ DATE OF BIRTH: ____________

RELATIONSHIP TO PATIENT: ___________ GROUP NUMBER: ____________________

IDENTIFICATION OR SOCIAL SECURITY NUMBER OF POLICYHOLDER: ______________

WHO REFERRED YOU TO THIS OFFICE? ______________________________

IN ORDER TO SECURE PAYMENT FOR MY TREATMENT THROUGH MY INSURANCE COMPANY, I AUTHORIZE **JANE Z. WOODROW, 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 **JANE Z. WOODROW, PH.D.** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE COMPANY AND THAT THE ENTIRE BILL IS MY RESPONSIBILITY REGARDLESS OF MY INSURANCE COVERAGE.

SIGNATURE: ____________________

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