Dena J. Klapperich, Psy.D., LLC

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New Patient Information

Name: _____ _____ _____ Patient Social Security# _____
Last First MI

Address: _____ _____ _____ _____ Age:_____ Birthdate:_____
Street City ST Zip

Gender: Male/Female/Non-Binary/Other:_____ Pronouns:_____

Marital Status (circle): Single Married Separated Divorced Other_____

Home Phone:_____ Work:_____ Cell:_____ Email Address:_____

If you are not available at the time that we contact you, may we leave personal information on voicemail or in email? Please indicate with an X where this information is acceptable to leave:

Home Phone____ Work Phone____ Cell Phone____ Email____

If Patient is an Adult: Occupation:_____ Employed by: _____
Business Address:_____

If Patient is a Minor, who has Custody or Guardianship:_____
In the event of an Emergency, who should be notified:_____
Relationship:_____ Phone/Cell:_____

Referred to Dr. Klapperich by Whom:_____

Assignment and Release

I certify that I, (or my dependent) have insurance coverage with _____ (insurance company) and assign directly to Dr. Dena J. Klapperich all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize Dr. Klapperich to release all information necessary (including diagnoses, mental health records and substance abuse records) to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Personal Financially Responsible for Account: _____ **(please print name)**

_____ **(please sign name)**

Relationship to Patient:_____ Date Signed:_____

Insurance Information for_____

(Name of Patient)

Subscriber's Name:_____ _____ _____

Last First MI

Relationship to Patient:_____

Subscriber's Birthdate: _____ Subscriber's Social Security #: _____

Subscriber's Address: _____ _____ _____ _____

Street City ST Zip

Home Ph:_____ Work:_____ Cell:_____ Email Address:_____

Employer:_____ Employer Phone:_____

Insurance Company:_____ Claims Phone Number:_____

Claims Address:_____

Group#:_____ Subscriber ID#:_____

Other Family Members Covered under this plan:_____

If known, Mental Health Benefits per year under this plan:_____

Is there a Secondary Insurance Policy? Yes___ No___ If yes, please complete the following:

Subscriber's Name:_____ _____ _____

Last First MI

Relationship to Patient:_____

Subscriber's Birthdate: _____ Subscriber's Social Security #: _____

Subscriber's Address: _____ _____ _____ _____

Street City ST Zip

Home Ph:_____ Work:_____ Cell:_____ Email Address:_____

Employer:_____ Employer Phone:_____

Insurance Company:_____ Claims Phone Number:_____

Claims Address:_____

Group#:_____ Subscriber ID#:_____ CoPay Amount (if known):_____

Other Family Members Covered under this plan:_____

If known, Mental Health Benefits per year under this plan:_____