CAROL J.STUART PsyD
2188 SW Park Place Ste. 205
Portland OR 97205

For Office Use: New____ Update____

Patient Name_____ Date of Birth_____
Home Phone_____ Email_____

Name of Responsible Party _____

Address_____

City, State, Zip _____

Patient's Employer_____Work Number_____

Parent/Spouse Name _____ Work Number_____

Primary Insurance _____Subscriber's Name _____

ID Number_____ Group Number _____

Primary Insurance mailing address_____

Secondary Insurance_____ Subscriber's Name _____

ID Number _____ Group Number _____

Secondary insurance mailing address _____

Please check if today's visit is result of:
_____motor vehicle accident Date of accident_____Auto ins carrier_____Policy#_____

_____on the job injury Date of accident _____ Worker's comp ins_____Claim#_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the above provider/providers to furnish my insurance company with any/all information requested concerning my present claim.
I hereby authorize the above provider/providers to bill my insurance company and to accept payment from that company on my behalf, for all services from time to time, relating to my care.
I acknowledge that I am responsible for all charges not covered by my insurance.
I understand that if there is an overpayment on my account, it will be refunded to the party who has paid in excess of the bill.

Signature Date