LT Psychology Services, LLC
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PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____

City_____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Ok to leave a voicemail? ☐ Y ☐ N

Email:_____ OK to receive emailed appointment reminders? ☐ Y ☐ N

Emergency Contact: _____ Phone: _____ Relationship to patient:_____

Who may I thank for referring you to me: _____

Please list the main reasons for seeking my services:

BILLING INFORMATION:

Person responsible for payment: _____

Address: _____ City: _____ State: ___ Zip: _____

Cell Phone: _____ Other: _____ Ok to leave a voicemail? ☐Y / ☐N

☐ SELF PAY-Not filing with insurance (If self-paying, skip the rest of this form)

Insurance Company: _____ Phone Number: _____

Member / ID#: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

PLEASE COMPLETE SECTION BELOW FOR ANY *SECONDARY* INSURANCE

Insurance Company: _____ Insurance Phone Number: _____

Insurance ID#: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

If possible, please email a picture of the front and back of the insurance card(s) at your earliest convenience. office@normanpsychology.com

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