John Roman Lutz, Ph.D. Licensed Psychologist

Phone: 770-592-9065 Fax: 770-592-9095

Please print this form, fill it out and bring it with you to your first appointment. For couples, each member must complete a form for themselves.

Patient Information – Part One

Date:_____ Referred by:_____

Patient's Name:_____ Date of Birth:_____

Address:_____

City:_____ State: _____Zip: _____

Home/Cell Phone: _____ Email address:_____

Employer: _____ Phone: _____

Presenting Problem: _____

_____

_____

Others living in the home:

Name	Age	Relationship	Work Phone

_____

_____

_____

Primary Care Physician: _____Phone: _____

I give permission to release information to my Primary Care Physician to coordinate my care: (initial)_____

In case of emergency, who should be notified?
Name/Relationship: _____ Phone: _____

I understand that fees are due at the time of service and that I am fully responsible for all charges incurred. I understand that I am responsible for missed appointments and cancellations of appointments without a 24 hour business day prior notice. I understand that I am responsible for legal and collection expenses if required for a delinquent account.
Signature: _____ Date: _____

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Patient Information – Part Two

Patient Name:_____

Insurance Information:

Name of Insurance Company: _____

Name of Policy Holder: _____ Date of Birth: _____

Employer of Policy Holder: _____

Member ID/Subscriber No.: _____ Group No.: _____

Assignment and release of information:

I, the undersigned, have insurance coverage with: _____

And assign directly to John Roman Lutz, Ph.D. all medical 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 John Roman Lutz, Ph.D. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured Date

Medicare Authorization:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to John Roman Lutz, Ph.D. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item nine of the CMS -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or healthcare provider agrees to accept the allowed charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deducible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature Date

240 Creekstone Ridge Woodstock, GA 30188