

KATHRYN NEEL PhD
7823 Hygiene Rd
Longmont, CO 80503
Ph: (240) 593-7561

Patient Information

Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Social Security Number:	Marital Status:	Sex: M or F
Employer or School:	<input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Student	
Referred by:		

Insured Information

Patient relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Name of Policy Holder:		
Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Date of Birth:	Social Security Number:	
Name of Employer or School:		
Employer or School Address:		

Insurance Policy Information

Name of Insurance Company:		
Address:		
City:	State:	Zip Code:
Membership ID #:	Group ID #:	
Insurance Company Telephone Number:		

Consent to Release and Informed Consent

I authorize the release of any medical information deemed necessary by Cornerstone Psychological Services to process my claim. I understand that I am responsible for all fees regardless of insurance benefits and those fees are due in full at the time of service. I understand that Cornerstone Psychological Services does not participate with any insurance plans except Medicare. I understand that it is my responsibility to determine if my insurance plan has out of network benefits and if a preauthorization is required, it is my responsibility to obtain authorization prior to receiving services. I understand that if I wish Cornerstone Psychological Services to provide any information to the insurance company, I will notify Cornerstone Psychological Services as to when and where the information should be sent. I will especially notify Cornerstone Psychological Services of any changes in my insurance plans.

(Signature)

(Date)

(Printed Name)

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

_____, have received the Notice of Privacy Practices

(Print Name)

(Signature)

(Date)

(Note: You have the right to refuse to sign this form)

For Professional Use Only

No signature for the following reason:

- Individual refused to sign
- Communication barrier prohibited obtaining a signed acknowledgement
- Emergency services prohibited obtaining a signed acknowledgement
- Specify other reasons _____