DEBORAH M. ROSENBERG, PH.D.
Licensed Psychologist
PO Box 5414, Frisco, Colorado 80443

3721 Evergreen Parkway, #10
Evergreen, Colorado 80439
303-695-0499

101 W. Main Street, #306
Frisco, Colorado 80443
970-668-8324

Patient Name: _____
Patient Birthdate:_____
Address: _____
City: _____ State_____
Zip Code: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Client Status: Employed __ Student __

Responsible Party (if other than above)
First Name: _____
Last Name : _____
Address: _____
City: _____ State: _____
Birth Date: _____
Marital Status: ___ Employed or Student: _____

Should this person be billed? _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email:_____
SS # _____

Insurance Information:
Name of Company: _____
Name of Behavioral Health Company (may be different):
_____
Address for Behavioral Health Claims: _____
_____

ID Number: _____
Group Number: _____
Policy Number: _____
Authorization: _____

Policy Holder Information:
Name:_____
Address: _____
_____
Birth Date: _____
Work Place Name/School: _____
What is relationship to the patient? Self Child Parent Spouse

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Marital Status: _____
Are you covered under school or employer?
Yes No

Coverage Information:

What is your copayment amount?_____
How many sessions are authorized?_____
Contact number for insurance:_____

Name of Client: _____

Agreements and Understandings:
(Please initial all)

1. I authorize the release of any medical or other information necessary to process my claims. I also request payment of insurance benefits to either myself or to the party who accepts assignment. _____
2. I authorize payment of medical benefits to Deborah M. Rosenberg, Ph.D. for the services provided. _____
3. I understand that I am responsible for ALL my copayments, deductibles and missed appointment charges.____
4. I understand that I am responsible for providing the correct and updated information necessary to bill the dates of service. In the event that the insurance does not cover the dates of service I understand that the balance is my responsibility. Updated insurance information must be received within 30 days of the date of service to bill properly. _____
5. I understand that if a payment is not received within 180 days, my account may be submitted to a professional collections agency. _____

Responsible Party Signature _____ Date: _____

Witnessed by:_____ Date: _____