JOY PICCOLINO, PSY.D.

Licensed Psychologist

BILLING INFORMATION

Please Check One

Date_____ _____I want to pay privately Complete 1, 4 & 5 below _____I want you to bill my insurance Complete 1, 2-4 as they apply, & 5 below

1. Patient Information

Patient Name (Print)_____ Date of Birth_____
Last Name First Name Initial

Street Address_____ Home Phone (____)_____

City_____ State_____ Zip_____ Cell Phone (____)_____

Employer_____ Occupation_____ Work Phone (____)_____

Emergency Contact _____ Emerg Phone (____)_____

2. Primary Insurance

Primary Insurance Company_____ Phone (____)_____

Policy/ID#_____ Group/Plan #_____

Policy Holder Information (If the patient is not the employee/policy holder):

Name_____ Relationship_____
Last Name First Name Initial

Street Address_____ City_____ State_____ Zip_____

Date of Birth _____ Employer_____

3. Secondary Insurance

Secondary Insurance Company_____ Phone (____)_____

Policy/ID#_____ Group/Plan #_____

Policy Holder Information (If the patient is not the employee/policy holder):

Name_____ Relationship_____
Last Name First Name Initial

Street Address_____ City_____ State_____ Zip_____

Date of Birth _____ Employer_____

4. Responsible Party *(If the patient is not the responsible party)*

Name_____ Relationship_____
Last Name First Name Initial

Street Address_____ City_____ State_____ Zip_____

5. Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to Joy Piccolino, PsyD, LP all insurance 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 Joy Piccolino, PsyD, LP to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date