JODIE SCOTT PHD
STILL POINT COUNSELING, INC
2802 ALOMA AVENUE, SUITE 101
WINTER PARK, FL 32792
(407) 628-3301

CAREFULLY READ AND PLEASE PRINT CLEARLY

PATIENT: LAST NAME: _____ FIRST NAME: _____ MI:_____

MAILING ADDRESS: _____ APT# _____ CITY:_____ STATE: _____ ZIP:_____

HOME PHONE: _____ CELL PHONE:_____ EMAIL_____

SS#: _____-_____-_____ (FOR INSURANCE REIMBURSEMENT PURPOSES ONLY)

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: ____F ____M MARITAL STATUS __S __M __D __OTHER

WHO IS RESPONISBLE FOR PAYMENT: __PATIENT FORM OF PAYMENT: __ CASH __ CHECK __ CREDIT CARD
__ INSURANCE (COMPLETE INSURANCE CARRIER INFORMATION BELOW)
__ OTHER (PLEASE SPECIFY) _____

PLEASE PROVIDE INSURANCE CARD(S) FOR COPYING

PRIMARY INSURANCE CARRIER: COMPANY NAME: _____ PHONE NUMBER_____

INSURED'S NAME: _____ DATE OF BIRTH: _____/_____/_____ RELATIONSHIP: ____SELF ___SPOUSE ___ CHILD

POLICY NUMBER: _____ GROUP NUMBER:_____

CLAIMS MAILING ADDRESS:_____CITY/STATE/ZIP_____

SECONDARY INSURANCE CARRIER: COMPANY NAME: _____ PHONE # _____

INSURED'S NAME: _____ DATE OF BIRTH: _____/_____/_____ RELATIONSHIP: ____SELF ___SPOUSE ___ CHILD

POLICY NUMBER: _____ GROUP NUMBER: _____

CLAIMS MAILING ADDRESS:_____CITY/STATE/ZIP_____

AUTO ACCIDENT/WORK COMP: CLAIM NUMBER _____ DATE OF ACCIDENT: _____

INSURANCE NAME: _____ PHONE NUMBER: _____

MAILING ADDRESS: _____ CITY/STATE/ZIP: _____

ADJUSTER'S NAME: _____ ADJUSTER'S PHONE NUMBER: _____

ATTORNEY'S NAME: _____ATTORNEY'S PHONE NUMBER: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES REGARDLESS OF THE DECISION REGARDING REIMBURSEMENT MADE BY MY INSURANCE COMPANY.

I AUTHORIZE ALL PAYMENTS DIRECTLY TO ***STILL POINT COUNSELING*** OF ANY INSURANCE BENEFIS OTHERWISE PAYABLE TO ME FOR SERVICES PROVIDED AND UNDER ANY INSURANCE POLICIES.

I UNDERSTAND THAT IF THE INSURANCE DOES NOT PAY AN INSURANCE CLAIM WITHIN ***90 DAYS***, THE CLAIM WILL BE RELEASED FOR PAYMENT BY THE PATIENT OR RESPONSIBLE PARTY.

I HEREBY AUTHORIZE MY PHYSICIAN TO RENDER MEDICAL SERVICES TO ME/OR TO MY MINOR CHILD, AND TO RELEASE ANY INFORMATION REGARDING ON MY BEHALF.

I AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE VALID AND ORIGINAL.

I HAVE REVIEWED THE ABOVE PATIENT REGISTRATION INFORMATION AND CONFIRM THAT IT IS CORRECT.

_____	_____	_____
PATIENT/INSURED'S SIGNATURE	**PATIENT/INSURED'S PRINTED NAME**	**DATE OF SIGNATURE**