Aubrey K. Ewing, Ph.D. & Associates, P.A.
1230 So. Federal Hwy, Suite 101
Boynton Beach, FL 33435

PATIENT INTAKE INFORMATION

Date _____ Referred by _____

Name _____ Date of birth _____

Age _____ Gender _____ Social Security No. _____

Address _____
Street Apt # City State Zip

Phone _____ Cell _____

Email address _____

Employer _____ Business phone _____

Name of spouse _____ Phone _____

Spouse's employer _____ Business phone _____

Insurance company _____ Name of policy holder _____

If minor, parent's name _____

Parent's address (if different) _____

Preferred phone number for messages: Home _____ Office _____ Cell _____ None _____

PLEASE READ AND SIGN

Release of Information. I authorize the release of any and all information required by my insurance company from records in the possession of Aubrey K. Ewing, Ph.D. & Associates, P.A. for the purpose of payment reimbursement. I understand that due to the requirement to release certain protected health information to insurance companies and managed care organizations, and that there are limits to the confidentiality of information I provide to this office.

Appointment Contract. If, for any reason, I cannot keep a scheduled appointment with this office, I will give at least 24 hours advanced notice of the cancellation. I understand that if I fail to keep my scheduled appointment without proper notification, that I will be responsible for payment of the full amount of the office visit charge.

Assignment of Benefits. I hereby assign all major medical and mental health benefits to which I am entitled including Medicare, private insurance, and any other health plan to Aubrey K. Ewing, Ph. D. & Associates P. A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assign to release all information necessary to secure payment.

HIPAA Disclosure. I acknowledge that I have read and understand the HIPAA disclosure describing the procedures of this office regarding my protected health information.

Patient signature _____ Date _____