www.TheMPInstitute.com
MidAmerican Psychological Institute, P.C.

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Please complete the following form so we can establish a client record. If at any time your original information needs to be updated, please inform your clinician immediately. Items left blank or incorrectly entered may lead to insurance claim denials that you will be responsible to pay.		
Client's Last Name	First Name	Middle Name
Gender:	Phone Number (Cell)	Phone Number (Alternate)
Address, City & State, ZIP Code		
Marital Status of client (*Circle)*: Single Married Other	Social Security Number	Birthdate (mm/dd/yyyy) Age
Employment status of client (*Circle)*: Full-time Part-time F/T Student P/T Student Other		Driver's License Number Driver's License State: _____
Primary Insurance Company		
Name of insured person if other than the client	Insured's Address, City, State & ZIP Code	
Insured's birthdate (mm/dd/yyyy)	Relationship to the insured	
Employer of Insured	Employer's Address, City, State & ZIP Code	
Name of Insurance Company	Insurance Company Address, City, State & ZIP Code	
Identification Number	Group Number	
Effective Date of Coverage:	Is this an HMO Plan? Yes No	Is authorization required? Yes No

Secondary Insurance Company			
Name of insured person if other than the client	Insured's Address, City, State & ZIP Code		
Insured's birthdate (mm/dd/yyyy)	Relationship to the insured		
Employer of Insured	Employer's Address, City, State & ZIP Code		
Name of Insurance Company	Insurance Company Address, City, State & ZIP Code		
Identification Number		Group Number	
Effective Date of Coverage:	Is this an HMO Plan? Yes No	Is authorization required? Yes No	

Would you like to receive appointment reminders? If so, choose an option below:	
Email to:	Phone call to:
Text message to:	None. Check here: ☐ (No reminder will be sent)

My signature below indicates that I give this office permission to release any information obtained during examinations or treatments of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the MidAmerican Psychological Institute. A photocopy of this assignment is to be considered as good as the original. An account that has not been paid for more than 60 days without payment arrangements being made will be eligible for collection proceedings. This may involve legal action, hiring a collection agency, or going through small claims court. This "Signature on File" will be valid from this date.

_____

Client (or parent/ guardian) signature, indicating agreement to the above statement — Date

_____

Print name