CHRISTIAN GLASGOW, PsyD, LMFT

Patient Information & Financial Agreement

*PLEASE PRINT CLEARLY *Required Information*

*Name (Last, First, M. I.) _____

*Address _____Email:_____

*City, State, Zip Code _____

*Home Phone _____Work Phone _____ Other _____

For verification purposes only: *Social Security # _____--_____--_____ *Date of Birth _____/_____/_____

*Sex: F M (*circle one*) Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired

*Employer _____ Position _____

Address _____ Phone _____

PRIMARY INSURANCE *(COPY ALL INFORMATION EXACTLY AS IT APPEARS ON YOUR CARD)*:

*INSURANCE COMPANY _____Employer_____

*Policy Holder's Name (leave blank if same as above)_____

*Policy/ID# Number _____ * Group Number _____*Co-pay $_____

*Claims Address _____*City, State, Zip _____

*Insurance Phone Number (on card)_____ *Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other

*DOB_____/_____/_____ * SS# _____--_____--_____ (For verification purposes only)Auth#_____

*OTHER INSURANCE _____ID#_____

EMERGENCY CONTACT

Name _____Relation_____ Phone_____

FINANCIAL RESPONSIBILITY & RELEASE OF INFORMATION AGREEMENT (SIGNATURE REQUIRED)

By signing below, I agree to the following policies of Christian Glasgow's practice and services he provides:

1) I authorize use of this form or a copy of it to convey my personal and insurance information to Christian Glasgow, PsyD, LMFT
2) I authorize release of information to my insurance company for claims billing purposes.
3) I authorize insurance payments directly to the provider.
4) I understand I am responsible for the full amount of my bill for services provided. Cash or Check is accepted.
5) CANCELLATION POLICY: I agree that I will be charged $50 ($100 for a House Call) for any appointment not kept which I have not provided 24 hours in advance notification of cancellation If my appointment is on a Monday, I must cancel by Friday.
6) Payment for services is ultimately my responsibility as insurance cannot be guaranteed.

SIGNATURE OF RESPONSIBLE PARTY_____ DATE:_____

Name (Printed) **Relation to Patient:**

PLEASE SUBMIT THIS FORM TO THE BILLING DEPARTMENT AT: christianglasgow.billing@gmail.com
OR FAX TO (801) 605-5293. YOUR INFORMATION WILL BE VERIFIED AND CONFIRMED VIA EMAIL.

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