Timothy Dunnigan, Ph.D.

Clinical Psychologist PSY10592

Client Information

Name:______________________ Date of Birth: ___________________

Address:______________________ Client's Social Security # ___________________

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Home Phone:______________________ Work Phone: ___________________

Insurance Information

Insured Person:____

Date of Birth: ____

Social Security #:____

Relationship to Client:____

Insurance Company:____

Insurance Address:____

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Policy member #:__________________________ Policy group #:__________________________

Is the patient covered by any other health plan? **Yes** **No**
(if **Yes**, please give details on the back of this form)

Insured's Work Information

Employed by:____

Work phone #:__________________________ Position:____________________________

Work address:____

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I authorize my insurance plan to pay Dr. Timothy Dunnigan any insurance payments otherwise payable to me for services rendered. I also authorize Dr. Dunnigan to release any information requested by the above named insurance company that might be needed to process claims.

I agree to accept full responsibility for that portion of charges that my insurance does not cover and for missed appointments or cancellations with less than 24 hours notice. I acknowledge that accounts are due and payable within thirty days and that failure to make a monthly payment toward my balance might result in a service charge and legal or professional collection action.

____ ___________________

Signature Date

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