Spectrus Psychological Services, Corp.

info@spectruspsych.com |www.SpectrusPsych.com

New Patient Information Required For Scheduling				
Patient Name				
Date of Birth				
Phone Number				
Email address				
If Patient Is A Minor, Please Offer The Below Information.				
Parent #1 Name				
Phone Number/ Email	(Phone)		(Email)	
Parent #2 Name				
Phone Number/Email	(Phone)		(Email)	
** Please note, if parents are divorced, signed legal documentation attesting to parental right to consent to treatment will be required upon scheduling. If this cannot be provided, both parents will need provide signed consent for treatment. **				
Benefit Information				
Insurance Company				
Member ID				
Group ID				
Provider Phone Number (See back of insurance card)				
Service Needs				
Primary Concern				
Services Requested	☐ Psychological Testing – Evaluation for autism, ADHD, and many other neurodevelopmental, psychiatric, and mental health diagnoses. ☐ Psychoeducational Testing – Evaluation for learning disabilities. ☐ Therapy – Individual, couples, family, and/or group counseling.			

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	☐ Social Work – Case management, skill building, resource coordination, etc.

Please note: Spectrus staff will not be able to schedule any services without the above information, please complete this form in its entirety. We will contact you to go over your estimated insurance benefits and scheduling options. In order to finalize scheduling, we will require TWO forms of payment on file, a primary and secondary debit or credit card. The secondary card will only be used in the event that your primary card is declined. A fee will be assessed for all declined card fees.

CONSENT TO COORDIANTE

If you are a legal adult and would like our staff to allow a third party to help you schedule your appointment, verify benefits, and set up payments, please complete the information below.

I do hereby consent to the exchange and/or disclosure of information regarding evaluation and treatment of the above-named person (new patient) and acknowledge that I have the legal right to grant this authorization of release of information.

By and Between:

Spectrus Psychological Services, Corp Clinical & Administrative Staff

And

Information for the individual with whom you would like us to coordinate.
Name:
Relationship:
Phone:
Email:

The disclosure of information and records authorized herein is done to facilitate scheduling, payment, and benefit coordination for services. I understand that I may revoke this authorization at any time, with the exception of actions which have been taken in reliance on this authorization, and that in any event this consent expires automatically at the expiration timeframe indicated below:

Expiration of consent to obtain/release information:

☐Upon termination ☐Other: _____

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_____ _____

Patient name (Printed) Date of Signature

_____ _____

Signature of Patient or Authorized Representative Relationship to Patient

☐ I attest that this form is electronically signed by the patient and not any third party. **

Submit your completed form via our encrypted system here: SUBMIT