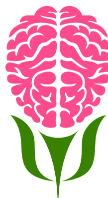

AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

2403 West Ben White Boulevard Austin, TX 78704
201 S. Lakeline Blvd. Ste 904 Cedar Park, Tx 78613
Office 512.707.2782 512.707.2783 fax
Website: www.austintestingandtherapy.com
Email: f.garces@austintestcenter.com

New Patient Information

Patient Name: ______________________________________

D.O.B_____________________SS# _______________________

Contact Number: __________________ Alternate Number: __________________

Current Mailing Address: ____

City: _________________State: _____ Zip: ________________

E-mail: ____

Primary Insurance: _______________________________

Policy or Member ID #: ___________________________Group #: ______________

Is primary card holder different than the above? Yes or No *If yes, please fill out primary card holder information below.

Card Holder's Name: ______________________________________

Card Holder's D.O.B. ______________ SS#______________________

Do you have a secondary insurance? Yes or No If yes, please fill out the following information below.

Secondary Insurance: ________________________________

Policy or Member ID #: ____________________________Grp# _______________

Please allow 2 business days notice if you are unable to attend your scheduled appointment or you will be charged a $100.00 cancellation/no show fee.

I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature: ________________________________

Printed name of person completing this document: _________________________

Relationship to the patient: ______________________________

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