Hillary Wishnick, PhD
6400 Thornberry Ct, Suite 620
Mason, OH 45040

Patient Name:________________________Today's Date:__________
Address:________________________City:__________State:______Zip:___
SSN:__________Birthdate:__________Age:______________
Home Phone #:______________Cell Phone #:________________
Referred by:________________________Family Physician:__________
Employer/School________________________Work number:__________
Single________Married________Divorced________Widowed__________

Responsible Party Information
Name of Person responsible for this account:________________________
Address:____________________City:__________State:______Zip:________
Home Phone #:____________SSN:____________Date of Birth:__________
Employer:________________________Work Number:__________
E-mail Address:________________________Cell phone#:__________
Spouse/Significant Other________________________________
Address:____________________City:__________State:______Zip:________
Home Phone #:____________SSN:____________Date of Birth:__________
Employer:________________________Work Number:__________
E-Mail Address:________________________Cell phone #:__________

Subscriber Information
Subscriber's Name:________________________Phone#:____________
Address:____________________City:__________State:______Zip:________
Social Security Number:____________________Relationship to patient:________

Insurance Information:
Primary Insurance:____________________Mental Health Carrier:__________
ID#:______________Group#:__________#sessions allowed per year:____
How much is your Mental Health deductible?__________Co-pay/co-ins amount:_______
Secondary Insurance:__________________Mental Health Carrier:__________
ID#:______________Group#:__________#sessions allowed per year:____
How much is your deductible?____________Co-pay/co-insurance amount:____________

I authorize the providers rendering service to submit claims to my health insurance company for all covered services rendered in this practice and authorize and direct the health insurance company to issue payment directly to the service corporation. I authorize my provider to furnish complete information to my health insurance company regarding services rendered, and hereby claim the amount of indemnity specified in my contract with my health insurance company.

I understand my provider utilizes an outside medical billing company. I authorize my provider of services to provide pertinent information to their medical billing company for the purpose of submitting claims to my insurance carrier.

________________________________ ________________
Signature of patient/Parent **Date**

05/04