Pathways Psychological Services, P.A.

7575 Golden Valley Road, Suite 230
Golden Valley, MN 55427
(763) 525-8590 Fax: (763) 525-8592

3145 Wellner Dr NE, Suite 302
Rochester, MN 55906
(763) 525-8590 Fax: (763) 525-8592

19230 Evans Street NW, Suite 202A
Elk River, MN 55330
(763) 241-8157 Fax: (763) 241-7670

In consideration for accepting assignment of my insurance benefits, I hereby release and agree to indemnify Pathways Psychological Services, its agents and employees, from all liability damages and costs arising from the acts or omission of any other clinic or physician, any hospital or any other person or agency.

*******PATIENT INFORMATION*******

_____/_____/_____/_____/_____/_____

Print First Name | Middle Initial | Last Name | Sex | Age | Date of Birth

_____/_____/_____/_____/_____/_____

Street Address | City | State | Zip | Marital Status | Spouse's Name

_____ (_____)_____ (_____)_____(_____)_____

Social Security Number | Work Phone | Cell Phone | Home Phone

*******MINOR CLIENT*******

I confirm the following information about _____:

- Parents are: □married, □separated, □divorced, □in process of divorce, □never married, □widowed.
- In the event of parents' separation and/or divorce, the court has set the following custody stipulations:
  Physical custody: □Mother □Father □Full Custody □Shared Custody □ Other_____
  Legal custody: □Mother □Father □Full Custody □Shared Custody □ Other_____

_____ Relationship: _____

Parent **OR** Legal Guardian Signature

*******RESPONSIBLE PARTY INFORMATION*******

_____/_____/_____/_____

Print First Name | Middle Initial | Last Name | Date of Birth

_____/_____/_____/_____/_____

Street Address | City | State | Zip | Social Security Number

_____ (_____)_____ (_____)_____ (_____)_____

Relationship to Client | Work Phone | Cell Phone | Home Phone

RECORDS RELEASE: I hereby authorize the release of any information by *Pathways Psychological Services* to my insurance company and/or immediate family (in the event of my death) on behalf of myself and/or my dependents.

By entering a phone number above, I give permission for it to be used by Pathways. I understand that if I have caller ID, the clinic name will be disclosed to others. Also, that if I have a blocked line, returning calls to me may be problematic.

I understand that <u>I am</u> financially responsible for charges not covered by my insurance contract and <u>I will</u> be responsible for payment of the entire bill. I will give a 24-hour notice of cancellation (*not including weekends or holidays*) for my appointment or I will be charged for the failed session.

Please keep your appointment card to verify in case of a discrepancy with appointment times.

Date _____ Signed _____