New Patient Demographic/Billing Information
Richard F. Sethre, Psy.D., L.P.

Name_____ Date _____

Birth date _____ Relationship status_____

Address_____
Street City State Zip Code

Email: _____

Emergency Contact (Name/telephone) _____

This form authorizes Dr. Sethre to send a bill to your insurance company and to otherwise communicate with your insurance company, as required by the company.

Primary Insurance: _____
ID/Member Number _____ Group Number _____
Policyholder's Name (if not the patient)
Policyholder's Birth Date (if not the patient)

Secondary Insurance: _____
ID/Member Number _____ Group Number _____
Policyholder's Name (if not the patient)
Policyholder's Birth Date (if not the patient)

I authorize the release of any medical information necessary to process this claim to the insurance company and/or the responsible party for this account.

I authorize payment of medical benefits for services rendered to me and/or my dependents to **Richard F. Sethre, PsyD , LP**

_____ _____
Signature **Date**

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL