Sidney W. Binks III, Ph.D.

Neuropsychologist/Clinical Psychologist

Neuropsychological Assessment
Psychoeducation Assessment
Forensic Assessment

SidBinks@aol.com
www.sidneybinksphd.com/p7.html

Individual/Couples Psychotherapy
Multi-Cultural Identity
HIV Issues

202 255-5187 (P) 3000 Connecticut Avenue, NW Suite 137 Washington, DC 20008 (F) 202 234-6373

INSURANCE/DEMOGRAPHIC INFORMATION

(Please Complete as *Thoroughly* as Possible)

Patient

Date:____________ Full Patient Name:____ DOB:____________

Full Patient Address:____ SS#: ____________

Zipcode

Patient Phone #'s: Home____________________ Work____________________ Cell____________________

Please tell me how you found Dr. Binks:______________________________ Medications:____________________

If ***Couples or Child*** Treatment, enter Partner/Parents Name/s:____

Send Bill to (Fill in ***only if*** different from above): Relationship to Patient:______________

____

Name Phone Full Address Zipcode

List 2 Emergency Contacts (***in addition*** to any names listed above):

______________________________ ______________________________

Contact #1 Phone Contact #2 Phone

Insured Person (Fill in ***only if*** different from above): Relationship to Patient:______________________

Name on Insurance Card:____ SS#:____________

Address/Phone#: ____ DOB of Insured:____________

Full Address Phone

Insurance

Insurance Company Name:________________________ Insurance Plan Name:________________________

ID #:______________________ Group Code or Group #:______________________

Phone # (# for Provider to use if 2 #'s are listed)__________________ Check One: HMO:_____ PPO:_____ POS:_____ Medicare:_____

Claim *Submission* Address:____

If you have Medigap Coverage, list Name/Address/Phone of Company here:

____

Company Name Full Address Phone

Insured's Employer:____

Authorization to Bill Insurance and Request Payment be Made Directly to Dr. Sidney Binks

I hereby authorize Sidney W. Binks III, Ph.D. to apply for benefits on my behalf for covered services rendered. I request payment from the above noted Insurance Company (and/or Medicare) be made directly to the above-named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including psychological information, for this or any related claim to the above-named billing agent (or in the case of Medicare part B benefits, to the SSA and HCFA) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing. If I have a Medigap policy, I request that payment of authorized benefits be made either to me or on my behalf to the above-named provider for any services furnished to me by that provider/supplier. I authorize any holder of psychological information about me to release to the Medigap Company listed above any information needed to determine these benefits payable for related services.

________________________	______________________________________	______________________________
Date	Patient/Guardian Signature	Patient/Guardian Printed Name

Do not Write Below This Line:

Deductible Amt:_____________ How Much is Met?:_______________ Will they pay Provider Directly:_______

Verify claims address_____ Verify if Within UC_______ If not, what is the UCR____________

% Covered____ Number of Allowed Sessions_______________