Carol Swenson, Ph.D.
Licensed Psychologist
Phone: (203) 938-9157
drcaarolswenson@gmail.com

REGISTRATION INFORMATION
(PLEASE PRINT)

Date:_____ Home Phone:_____

Patient:_____

Street Address:_____

City:_____State:_____Zip:_____

Sex:___Age:_____Date of Birth:_____Single__Married__Divorced__Separated__Widowed:__

Person Responsible for Payment:_____

Employed By: _____
Business Address:_____
Occupation:_____Business Phone:_____
Social Security #:_____

Insurance Information:
Name of Primary Insurer:_____
Address:_____
_____Phone #:_____
Contract #:_____Group #:_____ID#:_____

ASSIGNMENT OF BENEFITS

The Undersigned hereby authorizes release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature on this document authorizes Dr. Swenson to submit claims for benefits, for services rendered or services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I,_____authorize _____
(Name of Insured) (Name of Insurance Company)
to pay and hereby assign directly to Carol Swenson, Ph.D. all benefits, if any, otherwise payable to me for her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that all insurance benefits, when paid to Carol Swenson, Ph.D. will be credited to my account in accordance with the above assignment.

_____
(Authorized Signature of Subscriber) (Date)