

**Jeff Georgi & Associates, LLC**

112 Swift Ave, Durham, NC 27705  
(919)286-1600

Date: \_\_\_\_\_

**Patient Information-PLEASE PRINT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Nickname \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Seperated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Student Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ School \_\_\_\_\_ Not a Student \_\_\_\_\_

Employment: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Employer Name \_\_\_\_\_ Not working \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ office phone # \_\_\_\_\_

Referred by \_\_\_\_\_

**FOLLOWING INFORMATION MUST BE COMPLETED FOR CORRECT BILLING**  
**Who is responsible for Co pays and Deductibles: COMPLETE NAME /ADDRESS**

**Primary Insurance Coverage- PLEASE DO NOT LEAVE ANY BLANKS**

Insurance Co \_\_\_\_\_ Managed Care Co. \_\_\_\_\_

Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_ Tel#( ) \_\_\_\_\_

**Please present your card to therapist to be photocopied**

Is precertification necessary? \_\_\_\_\_ (if not sure call your ins. carrier)

If Yes, Certification # \_\_\_\_\_ # of visits \_\_\_\_\_ Start \_\_\_\_\_ End \_\_\_\_\_

Name of Policyholder \_\_\_\_\_ ( Must match to policy# above) Relationship to client \_\_\_\_\_

Address of Policyholder \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ (required) Home # \_\_\_\_\_ Work# \_\_\_\_\_

Policyholder SS # \_\_\_\_\_

**Assignment and Release**

I, the undersigned certify that I (or my dependent) has insurance coverage stated above and assign payment directly to entity named above all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance. I am entitled to a copy of this agreement by requesting same.

Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE ONLY: (REV. 01/08)

**DX** \_\_\_\_\_ **DATE OF FIRST VISIT** \_\_\_\_\_