William M. Boylin, Ph.D.

Individual, Marital and Family Psychotherapy
6 Way Road
Middlefield, CT 06455
860-349-7033

Patient Data Form

Last Name:_____ First Name:_____

Address: _____

City: _____ State:_____ Zip:_____

Date of Birth: _____ / _____ / _____ SSN# _____-_____-_____

Email: _____

Best Contact Phone #: _____ Alternate Phone #: _____

Insurance Company Name: _____

Name of Card Holder and DOB (Subscriber): _____ _____/_____/_____

ID #:_____ Group Number:_____

Employer: _____

Mental Health PH#: _____ (please see back of the card)

Authorization #: _____ If you have not obtained an authorization you must do so TODAY-please call the office with the authorization #, start date and end date and # of sessions.

COPAY: $_____ Copays are to be paid at the time of the session.

I authorize the release of any medical information necessary to process all claims.

Missed and less the 24 hour cancelled appointments are not covered by INS and will be billed directly to the client or responsible party.

Signature:_____ Date: _____