ANDREW M. PROKOPIS, PsyD
PO Box 320711
West Roxbury, MA. 02132
andrewprokopis@hotmail.com
707.292.1910

Personal Information

Patient/Client Name _____
Address _____
City, State, Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Date-of-birth _____
Sex (Male/Female) _____

Health Insurance Information

Insurance Company _____
Insur. Co. Address _____
Insur. Co. City/State/Zip _____
Insur Co. Phone # _____
Identification # _____
Referring Provider _____
Referring Provider NPI # _____
Policy Holder Name _____
Policy Holder DOB _____
Relationship to Patient _____
Subscriber Employer _____
Group # _____
Secondary Insurance Co _____
Secondary Insur. ID# _____
Pre-certification # _____
# of Sessions Pre-certified _____

Authorization to Pay Insurance Benefits: I hereby direct my insurance carrier to make payments directly to Andrew M. Prokopis, PsyD, for health insurance benefits otherwise payable to me, but not to exceed the Provider's regular charges. I understand that I am financially responsible for charges not covered by this authorization (including insurance co-payments and deductibles that are due at the time of service). This assignment of benefits shall be valid for the duration of my treatment.

Signature of Patient / Guardian _____ Date: _____

Authorization For Release of Information: I hereby authorize the Andrew M. Prokopis, PsyD and his office billing staff or agency to release billing and medical information to my insurance company necessary to process claims for services rendered to me by the Provider. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information, which by law may only be released by specific consent.

Signature of Patient / Guardian _____ Date: _____
Co-pay $_____