



PATIENT/ INSURANCE INFORMATION FORM

Please check your doctor's or therapist's name:

- Joel L. Young, M.D.
Karen Donoughe, M.S., M.A., L.L.P.C., N.C.C.
C. Lynn Florek, M.A., L.L.P., L.P.C.
Debra Gorney-Jankowski, M.S.N., R.N., C.S.
Tanya Kuprianiak, M.A., L.L.P.
Marie McMahan, L.M.S.W., A.C.G.
Nikhil Vora, M.D.
Melissa Oleshansky, PhD
Erika Parsons, M.A., L.L.P.C., N.C.C.
Judy C. Redmond, M.A., L.P.C., N.C.C.
Carol L. Rembor, M.S., A.P.R.N., B.C.
Jaime M. Saal, M.A., L.P.C., N.C.C.
Jessie Spitsbergen, M.A., L.L.P.C., N.C.C.
Yvonne Stumpf, M.S.W., R.N., C.S.
Kathy Tessmar, L.L.M.S.W.
Mindy Layne Young, J.D., M.S.W., C.S.W.

Patient Info: Patient Name: Social Security Number: Street Address: City: State: Zip: Primary Phone Number: please circle: Cell/ Work/ Home OK to leave detailed message? Y N Secondary Phone: please circle: Cell/ Work/ Home OK to leave detailed message? Y N E-Mail Address: What is the best way to contact you btw 8am and 6pm? please circle: Primary Phone # / Secondary Phone # / E-Mail Birth Date: Age: Sex: Marital Status: Employer (if applicable): Please circle one: Hourly Salary Retired

Responsible Party (Insurance Policyholder) Info—PRIMARY INSURANCE POLICY: Name: Relationship to Patient: Social Security Number: Birth Date: E-Mail Address: Street Address: City: State: Zip: Primary Phone Number: please circle: Cell/ Work/ Home OK to leave detailed message? Y N Secondary Phone Number: please circle: Cell/ Work/ Home OK to leave detailed message? Y N E-Mail Address: Birth Date: Age: Sex: Marital Status: Employer (if applicable): Please circle one: Hourly Salary Retired Type of Insurance: Policy Number: Group Number: Effective Date:

Responsible Party (Insurance Policyholder) Info—SECONDARY INSURANCE POLICY (if applicable): Name: Relationship to Patient: Social Security Number: Birth Date: E-Mail Address: Street Address: City: State: Zip: Primary Phone Number: please circle: Cell/ Work/ Home OK to leave detailed message? Y N Secondary Phone Number: please circle: Cell/ Work/ Home OK to leave detailed message? Y N E-Mail Address: Birth Date: Age: Sex: Marital Status: Employer (if applicable): Please circle one: Hourly Salary Retired Type of Insurance: Policy Number: Group Number: Effective Date:

**Emergency Information:**  
**In Case of Emergency, Please Notify:**  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Primary Phone Number: \_\_\_\_\_ please circle: Cell/ Work/ Home OK to leave detailed message? Y N  
Secondary Phone Number: \_\_\_\_\_ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

**Referral Information:**  
May we release information to your referral source? Y N Name of Referring Party: \_\_\_\_\_  
Facility: \_\_\_\_\_ City and State: \_\_\_\_\_

**Release of Information:**  
I hereby authorize the Rochester Center for Behavioral Medicine to release information regarding my/my child's case to my insurance company and to any other referring colleague at the Rochester Center for Behavioral Medicine.  
Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Responsibilities:** I understand that I am fully responsible for all charges incurred, regardless of any insurance policy(ies). I agree to pay in full any and all debts that I may incur in the course of treatment for either myself or as a guarantor. I further understand that all fees are payable at the time of service.  
Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_