Richard W. Rodgers, Ed.D., ABPP, Licensed Psychologist
1595 Selby Ave, Suite 210; St. Paul, MN 55104

Patient Information

Patient Name:_____Date of Birth_____

SS#_____ Gender_____ Marital Status_____

Address_____

City_____ State_____ Zip code_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Emergency Contact_____ Phone Number_____

Insurance Information

Insurance Company_____

Policy/ID#_____ Group #_____

Policy Holder Name_____Relationship to Patient_____

Date of Birth of Policyholder_____

Payment Policy and Consent

I/We understand that Dr. Richard Rodgers, a solo practitioner, will bill my insurance carrier on my behalf and disclose the following information: a statement of my diagnosis, the services I/We received, the dates of service, and any required narratives. The insurer and provider of services will use this information to process and /or determine reimbursement for services provided.

I/We understand that no other information will be released and no other uses will be made of this information except for those previously communicated to me.

I understand that I am responsible for any charges denied by my insurance carrier and /or my deductible, copay and /or coinsurance. I also understand that I am responsible for the charge of $150 for any session not attended without adequate notification of at least 24 hours.

I/We authorize payment of medical benefits to Richard W. Rodgers, Ed. D.,LP for services rendered.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

For Office Use Only: DX Code (ICD-9)_____ Self-Pay:_____