

Deborah C. Neel, Ph.D.

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Be sure to have your insurance card copied.

Have you called your company to request pre-certification for sessions?

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Telephone: home _____ work _____ cell _____

Address: _____

City: _____ NC Zip _____ Birth Date: ____/____/____ Sex: M F

Social Security Number: ____/____/____ E-mail: _____ (not encrypted)

Marital Status: single married other Employment: employed full time student part time student

Employer (or School) Name: _____

Insurance Company/ where do out-of-network providers mail mental health claims:

Policy Holder: (if other than patient)

Relationship to Insured: self spouse child other

Employer's Name: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Telephone: home _____ work _____ cell _____

Address: _____

City: _____ NC Zip _____ Birth Date: ____/____/____ Sex: M F

Social Security Number: ____/____/____ E-mail: _____ (not encrypted)

Marital Status: single married other Employment: employed full time student part time student

Emergency Contact: (relationship to patient _____)

Last Name: _____ First Name: _____ Middle Initial: _____

Telephone: home _____ work _____ cell _____

Address: _____

- I authorize the release of any medical or other information necessary to process insurance claims.
- I authorize Deborah C. Neel, Ph.D. to exchange health information to the person(s) you designate in the event of an emergency. This authorization remains in effect until termination of treatment or unless you notify this office in writing with a new contact person(s).
- I am the party responsible for payment.

Signature: _____

Date: _____

Print Name: _____

Referred to this office by: OK to thank referral? Yes___ No___