Thomas E. Mates, Ph.D.

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National Register of Health Service Providers In Psychology

Bus. 910-256-6163
Fax 910-256-6748

Date ______________________________ Home Phone ________________________

Patient ____
Last Name First Name Middle Initial

Street Address____
City ______________________________ State ____________Zip Code ____________
If A Minor: Parent's/Guardian's names _____________________________________
School (if a minor): _________________________________ Grade ______________

Birthdate ____________________Age______Sex: ____M____F, Marital Status________

Patient or Parent employed by ____
Business Address ____
Business Phone _______________________ Home Phone ___________________
Spouse or other parent employed by ____
Business Phone _______________________ Home Phone ___________________
Who is responsible for payment of this account? _____________________________
Patient SS# ______________________________ Spouse SS# ____________________

Do you have insurance? ________Yes ________No If yes, please complete
Name & Address of Insurer____
Subscriber Name ____
Subscriber ID# _________________ Subscriber Group # ______________
Name of Secondary Insurer (if any) ____
Subscriber Name ____
Subscriber ID# _________________ Subscriber Group # ______________

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I acknowledge that my signature on this document authorizes my therapist to submit claims for benefits or services rendered without obtaining my signature on each claim, and that I will be bound by this signature as though I had personally signed the claim.

I, ____________________ (name of insured) hereby authorize (ins. co.)________________
To pay and hereby assign directly to Mates Mental Health Services, PLLC all benefits, if any, payable to me for services as described on the attached form. I understand I am financially responsible for all charges incurred.

_________________________________ _________________________________
Authorized signature of subscriber Date