MASSACHUSETTS
PSYCHIATRIC SERVICES, LLC.
128 MAIN STREET, SUITE #3
STURBRIDGE, MA 01566
TELEPHONE: (508) 418-6888

Patient Information

Patient Name: _____DOB_____Soc Sec #_____

Marital Status: Single Married Widowed Divorced (circle one)

Address: _____City/State: _____Zip code: _____

Mailing Address: _____City/Sate:_____Zip Code _____

Home Ph: _____ Cell Ph:_____ Work Ph:_____Email_____

Would you like a reminder of your appointment? If yes circle which method – TEXT, CALL, or EMAIL

Would you like to sign up for our patient portal? Yes or No (circle one) (make sure to included your email above)

If yes you will be emailed an invitation. You will need to approve the invite and send back to us. We will then activate the portal.

Occupation: _____

Emergency Contact: _____ Relationship: _____Ph:_____

Primary Care Physician: _____ Phone: _____

Do You have allergies to medications? Please RX & reaction if any _____

Primary Insurance Information:

(Please note we are not a Masshealth provider and cannot accept any type of Masshealth insurance)

Insurance Carrier (Primary): _____ Copay _____

Policy# _____ Group#_____

Policy Holder: _____ Relationship to Policy Holder: _____

Subscriber's D.O.B.: _____

Secondary Insurance Information (if applicable):

Insurance Carrier (Primary): _____ Copay _____

Policy# _____ Group#_____

Policy Holder: _____ Relationship to Policy Holder: _____

Subscriber's D.O.B.: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges incurred for any professional services rendered. I have read all the information on this sheet and I have answered the above to the best of my knowledge. I will notify you of any and all changes in my health status or the above information.

I authorize the release of any payments and medical information necessary to process/pay claim(s) for services furnished and provided by Massachusetts Psychiatric Services, LLC. I request that payment of authorized insurance companies be made to Massachusetts Psychiatric Services, LLC. I authorize any medical information about me to be release to Massachusetts Psychiatric Services and its agents for related services.

I am aware that I may be billed $50.00 for missed appointments and for sessions canceled with less than 24 hours' notice. I am also aware that Massachusetts Psychiatric Services will charge a $30.00 fee for any returned checks.

Signature: _____Date_____

Parent/Guardian (if minor) or Responsible Party: _____Date_____