



BUCKINGHAM PSYCHOLOGICAL SERVICES

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Aurora, CO 80014
Phone: 303-750-7411 • Fax: 303-750-5309
Buckpsy.com

Demographic Information

First Name: _____

Middle Initial: _____

Last Name: _____

Date of Birth: _____

Social Security Number: _____

Sex: M F

Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Email Address: _____

Referring Physician Name (Optional): _____

Describe reason you are seeking therapy for _____

Insurance Information

Primary Insurance Company: _____

Subscriber ID # (including letters): _____

Group Number: _____

Insurance Policyholder Full Name: _____

Insurance Policyholder Date of Birth: _____

Insurance Policyholder Address: _____

Insurance Policyholder Relationship: Self Spouse Child Other

Insurance Policyholder Social Security Number: _____

Insurance Policyholder Sex: M F

Note: All information is required.

Patient Authorization

I authorize the release of any medical and insurance information necessary to process any claim.

Patient Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Patient Full Name: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician, if a referral is required by my insurance plan. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Patient Full Name: _____

Who do we notify in case of an emergency: _____

Phone Number: _____

Note: All information is required.

Please sign and return

Email completed foam to: bps@buckpsy.com or fax to: 303-750-5309