**Psychiatric Services, LLC**

**Eileen Spangler, Psychiatric NP**

5265 N Academy Blvd #3300

Colorado Springs, CO 80918

(719)-644-0040 Fax – (719)452-3491

[**www.SPANGLERNP.com**](http://www.SPANGLERNP.com)

***Name:*** *First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Social Security #: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_***

***Gender: Male\_\_\_\_\_Female\_\_\_\_\_ Marital Status: M S D W***

***Home Phone: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Cell: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Messages may be left on: Home phone\_\_\_\_ Cell phone\_\_\_\_ Work phone\_\_\_\_ Email\_\_\_\_***

***Occupation/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***EMERGENCY CONTACT:*** *Name:* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***PRIMARY INSURANCE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***PATIENT’S RELATIONSHIP TO POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***POLICY HOLDER’S DOB \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_***

 ***INSURED ID #:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***GROUP/POLICY #:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***SECONDARY INSURANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 ***INSURED ID #:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***GROUP/POLICY #:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

I authorize Psychiatric Services to release information from my medical records as may be necessary/requested by my insurance

Company to process claims and to my primary care and/or referral providers for continuity of care. I authorize payment directly to

Psychiatric Services of the benefits otherwise payable directly to me under the terms of my insurance. I understand I am financially

responsible for charges not covered as detailed in the Practice Policies. If collection action is necessary, I understand that I am

responsible for payment of all expense of collecting my unpaid balance, including attorney fees and that I specifically relinquish

privilege of confidentiality that may be necessary to process my account. This signature also is my consent for treatment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

(Parent if minor)