DR. KATE BURTON, PSYD, PLLC

Licensed Clinical Psychologist

2065 Sidewinder Drive Ste 200 . Park City . Utah . 84060

Phone (435) 200.5525 ⍰ Fax (435) 275-1676

REFERRING PHYSICIAN OR FACILTY

NAME

ADDRESS

CITY | STATE | ZIP

PATIENT INFO

LAST NAME | FIRST | MI

BIRTHDATE | SEX | MARITAL STATUS

MAILING ADDRESS

PHYSICAL ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

CITY | STATE | ZIP

CITY | STATE | ZIP

EMAIL OK TO LEAVE MESSAGE? Y❑ N❑

OCCUPATION

EMPLOYER

HOME PHONE OK TO LEAVE MESSAGE? Y❑ N❑

CELL PHONE OK TO LEAVE MESSAGE? Y❑ N❑

WORK PHONE OK TO LEAVE MESSAGE? Y❑N❑

OTHER INFO

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT THAN PATIENT)

LAST NAME | FIRST | MI

ADDRESS

CITY | STATE | ZIP

EMAIL

HOME PHONE | CELL PHONE

EMERGENCY CONTACT

PARENT/GUARDIAN (IF MINOR) ❑ SPOUSE ❑
NEAREST RELATIVE OR FRIEND ❑ SIG. OTHER ❑

LAST NAME | FIRST | MI

ADDRESS

CITY | STATE | ZIP

EMAIL

HOME PHONE | CELL PHONE

INSURANCE

INSURANCE COMPANY | IDENTIFICATION NUMBER | GROUP NUMBER

INSURED'S LAST NAME | FIRST | MI | INSURED'S BIRTHDATE | RELATIONSHIP TO PATIENT

I hereby authorize release of information necessary to file a claim with my insurance company and I hereby assign all mental health benefits paid by my insurance company to Dr. Kate Yoder. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for any balance not covered by my insurance company. A photocopy of this assignment is valid as the original.

X

PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR) | DATE

X

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT THAN PATIENT) | DATE

PAYMENT INFO

PREFERRED METHOD OF PAYMENT:

CHECK OR CASH AT THE TIME OF APPOINTMENT ❑ MONTHLY AUTOMATIC CREDIT CARD ❑

VENMO @_____ ❑ PAYPAL or CHASEPAY @DRKATEYODER@GMAIL.COM ❑

Regardless of your preferred method of payment, you must provide and maintain on file a valid credit card for collection of all unpaid balances. Please be advised that many Health Savings (HSA, HRA, etc.) cards do not authorize mental health/therapy services to be charged to their cards. In the event that your Health Savings card cannot be charges, our billing service will ask for additional payment info to be kept on file.

CARD HOLDER LAST NAME | FIRST | MI

CARD TYPE: CREDIT ❑ DEBIT ❑ HEALTH SAVINGS ❑

BILLING ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

CARD NUMBER

CITY | STATE | ZIP

EXPIRATION DATE | 3 DIGIT CCV ON BACK (AMEX 4 DIGIT ON FRONT)

I verify that all information provided is correct and that I, the undersigned, am the card holder of the above credit card. I further verify that the signature below is my signature as indicated on the reverse of my credit card. I hereby authorize Dr. Kate Yoder (to charge my indicate credit card without an imprint for any outstanding portions of my account balance.

X

CREDIT CARD HOLDER | DATE