SLEEPWELL

❖ A PRIVATE PRACTICE
SLEEP DISORDERS SERVICE
GILA LINDSLEY, PH.D., A.C.P.

Diplomate,
American Board of Sleep Medicine
Licensed Psychologist

7 WHITE PINE LANE, LEXINGTON, MA 02421-6321

Patient Information:

Name _____

Street _____

Apt. _____

City, State, Zip _____

Tel home (___) _____

Tel work (___) _____

E-Mail address _____

Date of birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Relationship to insured: _____

Marital status: M ___ S ___ Other ___

Employed __Y __ N

Student: ___ Full time ___ Part time

Name, address, phone of patient's primary physician:

_____

_____

Information about the Insured:

Insured's ID # _____

Insured's name _____

Street _____

Apt. _____

City, State, Zip _____

Tel home (___) _____

Policy group or FECA number _____

Date of birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Employer's name or school name:

_____

About your insurance:

Authorization Number: _____

Name of your Insurance Company:

_____

Mental health manager for company:

_____

Street _____

Additional address_____

City, State, Zip _____

Telephone: __(_____)_____

Contact person if known: _____

Is there another health benefit plan?

____ Yes ____ No

If yes, please provide same information as for primary insurance:

_____
_____
_____
_____

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ _____
Signature of Patient Date

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____
Signature of Insured

TELEPHONE: (781) 862-7331
FAX: (781) 674-2526
INTERNET: SLEEPWELL@ATTBI.COM