Registration Information
Please Print

_____
(Date)

Patient Name: Last_____**First**_____**M.I.**_____

Address_____

City_____**State**_____**Zip**_____-_____

Home Phone( )_____**Work Phone( )**_____

Cell/Other Phone( )_____**Email Address**_____

Age_____ **Date of Birth**_____-_____-_____**Female/Male** _____**SS # (last 4 digits)** xxx-xx-_____

Marital Status_____**Employer/School**_____

Referred by_____**Email**_____

Primary Care Physician/Address/Phone_____

In Case of Emergency call: Name_____**Phone#( )**_____

Person responsible for payment_____**DOB:**_____

-Relationship to patient_____**Social Security #**_____

-Employer of person responsible for payment_____

-Address of responsible party unless same as above_____

-City_____**State**_____**Zip**_____-_____

I am responsible for full & timely payment for services I request:_____
Signature of Responsible Party

Complete this part only if you plan to request reimbursement from insurance. Please discuss any parts of this that need clarification with your physician/therapist.

1. **Check whether your insurance coverage requires pre-certification (the phone number should be on your card.**
2. **Ask a secretary to make a copy of your insurance card(s). Employer:**_____
3. **Primary insurance:**_____**PolicyHolder:**_____**DOB:**_____
4. **Secondary insurance:**_____**PolicyHolder:**_____**DOB:**_____
5. **I authorize my physician/therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.**

   Signature of responsible party_____**Date**_____

6. **I authorize the insurance company to reimburse my physician/therapist directly.**

   Signature of responsible party_____**Date**_____

For office use only: C_____**D**_____**E**_____**F**_____

Patient will submit for insurance themselves _____**Yes** _____ **No. Other arrangements agreed upon:**

_____

Therapist Name:_____

Please Print

Patient Name: (Last, First Middle Initial):_____

1) Please list any medical conditions, include medications being taken for these conditions:

_____

_____

_____

2) Please list any allergies, include medications being taken for these conditions:

_____

_____

_____

3) Please list any previous psychiatric treatment:

Therapist Name	Dates Seen	Medications (if any)

4) Please list any current psychiatric medications:

_____

_____

_____

5) I hereby give permission to you to notify my primary care physician of my contact with you (information listed on page 1 of Registration Information form)

Signed:_____ **Date:**_____

(Patient or Parent or Guardian)

OFFICE POLICY

1. **PAYMENT FOR PROFESSIONAL SERVICES:**
   Payment is due at the time services are rendered. You may prefer to pay on a monthly basis. You will receive a bill at the end of each month. Please pay the full balance which appears on the bill by the end of each month; past due balances may lead to collection. Any other payment arrangements should be discussed with your clinician.
2. **INSURANCE:**
   It is most likely that your clinician will be an out of network provider for any insurance plan that you might carry. The suite secretary can usually answer questions about this for your specific situation. If your insurance plan requires pre-approval before your first appointment please contact them to obtain this before your first session.

   Upon request our office will file your insurance claim forms for you on a monthly basis. The amount of reimbursement from the insurance company will depend upon your policy. Although we try to be helpful in any way that we can, we are not responsible for follow up of your insurance claims. Please contact your insurance company directly concerning problems that may arise regarding reimbursement.
3. **APPOINTMENT CANCELLATION POLICY:**
   If for any reason you are unable to keep a scheduled appointment, you are responsible for calling to cancel. Unless you cancel at least 24 hours prior to the scheduled appointment time you will be charged for the missed appointment. These charges are not covered by insurance.
4. **COVERAGE:**
   After hours, weekends and during vacations your clinician or their covering counterpart will be available to you for emergencies by calling the office telephone number and requesting the answering service. We request that all issues that can be attended to during business hours be handled during office hours. All clinicians have a voice mail box to be used for non-emergent messages.
5. **LENGTH OF SESSIONS:**
   Each session has a designated time limit. If you are late for a session, that time is lost from your session.
6. **CONFIDENTIALITY:**
   Maintaining your confidentiality is a very high priority. Only in instances in which your life or the life of another is at risk does your clinician have the right to break this without your consent. Your clinician may discuss your treatment with the doctor/therapist who will be covering for them when they are away to be sure that your needs are met.

Please feel free to discuss any questions related to these policies with your treating clinician.

_____ _____

Signature of patient **Signature of responsible party** **Date**