Registration Information
Please Print

_____
(Date)

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

Address_____

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

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

Cell Phone( )_____ **Other Phone( )**_____

Age_____ **Date of Birth**_____-_____-_____ **Female/Male** _____ **Social Security #**_____

Marital Status_____ **Employer/School**_____

Referred by_____

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).**
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:_____

Registration Information

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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's 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 of Page 1 of Registration Information Form).

Signed:_____ **Date:**_____
(Patient or Parent of Guardian)

Velissarios Karacostas, M.D., Ph.D.
3001 Highland Avenue
Cincinnati, OH 45219
(513) 961-8484 Fax (513) 487-3760

Release of Information

I hereby give permission to _____ to release

information to _____about the evaluation

and/or treatment of the medical, psychiatric, psychological or substance abuse conditions of

_____

whose date of birth is _____. This information is to be used only for the

purpose(s) of: gathering information for treatment planning _____yes _____no

other _____

Also I give permission for exchange of information between both parties _____yes _____no

I understand that by State and Federal law: (1) only the specified information can be released to the specified recipient; (2) I may revoke this authorization at any time in writing; revocation has no effect on prior action. This release will expire 180 days from the signature date unless specified otherwise. The release of any information concerning AIDS, HIV infection or AIDS-Related Complex are authorized unless specifically excluded.

_____
Signature

_____
Date

_____
Guardian (if indicated)

Prohibition of Redisclosure: Federal law (42CFR, part 2) prohibits redisclosure of any of the above information except with specific written consent by the person to whom it pertains.
A facsimile of this signed document may be accepted in lieu of the original.