ANNE DUDLEY, M.S.W., L.I.S.W.
3001 HIGHLAND AVENUE—CINCINNATI, OH 45219-2315
TELEPHONE (513) 961-8846 FAX (513) 487-3770
Ohio License # 1-3807

PATIENT REGISTRATION

Date________________________________

Name____
Last First Middle/Maiden

Home Address____
City/State/Zip

DOB: ___________________ Social Security Number ____

Telephone____
Home Work Cell

Special Instructions for Messages? ____

Employement____
Work Address

Married__________________________ How long? ____

Single_________________ Living with partner? ________________________ How long? _____________________

Previous Marriage Dates____

Children and Ages ____

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Other Family Members in the Home ____

Referred by ____

Primary Physician ____

Current Medications ____

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AUTHORIZATION – RESPONSIBILITY AGREEMENT

The undersigned hereby authorizes Anne Dudley, L.I.S.W. to release medical information related to my medical condition and treatment to any insurance company for filing insurance claims. I hereby authorize any insurance company to pay proceeds of any benefits due me directly to Anne Dudley, L.I.S.W. A copy of this authorization can be considered as an original for above purposes.

Regardless of any insurance benefits, I understand that I am fully responsible for the payment of all fees for services rendered.

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Signature of Patient Signature of Responsible Party

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OFFICE POLICY

1) **Payment for Professional Services:**
   Payment is expected at the time of service. Any monthly balances are to be paid within 10 days of the billing date. Any other payment arrangements should be discussed with Anne Dudley for approval. It is your responsibility for payment of fees for professional services.

2) **Insurance:**
   We can assist you with your insurance claims; however, we are not responsible for follow-up of Your insurance claims.

3) **Appointment Cancellation Policy:**
   At least 24 hour notice for cancellation is required. If less than 24 hour notice is given, full charge will be made unless another patient is scheduled for the cancelled time.

4) **Coverage:**
   I am a separate and independent practitioner who shares space in this building along with other therapists. Other therapists will cover from time to time while I am on vacation or on my day off. Anyone covering for me can be reached at my office telephone number (513) 961-8846 (24 hour answering service).

____________________ ____________________ ____________________

Signature of Patient Signature of Responsible Party Date

Person Responsible for Bill ______________________________

Insurance Company ____________________

Subscriber Name____________________ Subscriber DOB:____________________

Contract Number/Group Number ______________________________

In case of emergency, please call ______________________________