

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 _____ Social Security # _____

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).
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)
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_____	_____	_____
_____	_____	_____
_____	_____	_____

- 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: _____
(Patient or Parent of Guardian)

Date: _____