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:_______________________

Please Print

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

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

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

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3) **Please list any previous psychiatric treatment:**

Therapist Name	**Dates Seen**	**Medications (if any)**

4) **Please list any current psychiatric medications:**

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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)

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