

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:**

<b>Therapist's Name</b>	<b>Dates Seen</b>	<b>Medications (if any)</b>
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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:** \_\_\_\_\_