Registration Information

Today's Date _____

Patient Name _____
Street Address _____ Apt_____
City _____ State_____ Zip Code_____
Home Phone (____) _____ Cell (____) _____
Date of Birth_____ Social Security _____ Gender M_____F_____

Marital Status: Single____Married___Separated___Divorced___Widowed____Partnered_____

Patient Employed by _____
Business Addresss_____ Suite _____
City _____ State _____ Zip Code_____
Business Phone (____) _____ Full time _____ Part time _____

Spouse Name _____
Date of Birth _____ Gender_____

Responsible Party for Payment (If Different from Patient or Spouse)

Name _____

Relationship to Patient:
Father _____Mother _____Guardian _____Power of Attorney_____

Street Address_____ Apt_____
City _____ State _____ Zip Code_____

Home Phone (____) _____ Cell (____) _____

Emergency Contact Person(s)
Name _____ Phone (____) _____ Relationship_____
Name _____ Phone (____) _____ Relationship_____

Primary Insurance Company_____
Subscriber Name _____ Date of Birth _____
Policy ID _____ Group ID _____

Secondary Insurance Company _____
Subscriber Name _____ Date of Birth _____
Signature _____
Policy ID _____ Group ID _____

I have read and received a copy of the doctor's privacy notice. Date_____
Patient/Responsible Party Signature: _____

Over

AUTHORIZATION – RESPONSIBILITY AGREEMENT

The undersigned hereby authorizes David Leonard, M.D. to release medical information related to my medical condition and treatment to any Insurance Company for filing insurance claim. I hereby authorize any Insurance Company to pay proceeds of any benefits due me directly to David Leonard, M.D. 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.

Signature of Patient/Responsible Party: _____
Date _____

OFFICE POLICY

1. Payment for professional Services:

Payment is expected at the time of service. Any monthly balances are to be paid within ten days of the billing date. Any other payment arrangements should be discussed with Dr. Leonard for approval. It is your responsibility for payment for fees for professional services.

2. Insurance:

We can assist you with your insurance claims: however, we are not responsible for filing and follow-up of your insurance claims.

3. Appointment Cancellation Policy:

At lease 24-hour notice for cancellation is required. If less than 24 hours notice is given, full charge will be made, unless another patient is scheduled for the canceled time.

4. Termination of Therapeutic Relationship:

Cancellation of three consecutive appointments or lack of at least one office visit every three months would indicate that you have chosen to terminate your relationship with me.

5. Coverage:

I am a separate and independent practitioner who shares space in this building along with other psychiatrists. Other doctors will cover from time to time while I am on vacation or on my day off. Any covering physician or I can be reached at my office number 513-961-8861 (24 hour answering service).

Please discuss any questions with Dr. Leonard.

Signature of Patient/Responsible Party: _____

Date_____