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)**

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:_____ **Date:**_____
(Patient or Parent of Guardian)