Patient Registration Form

Patient's Name: ____ Date of birth: _____________ Sex _____
First Middle initial Last

Mailing Address: ____

Physical Address: ____

Phone: (H) __________________ (W) ______________ (cell) _________________ Message ok? ____________

Email: ____ Preferred method of contact __________________

Social security #: ___________________Marital Status __________Family doctor ___________________________

Work Status (circle one): Full-Time Part-Time Retired Not Employed Student: Full-Time Part-Time

Emergency Contact Name & Phone: ____

Emergency Contact's Relationship to client: _____________________________

Insured Info, if different from patient

Name of insured: ____ Sex: ______

Insured's Street Address: ____

Insured's City, State, Zip: ____

Patient's relationship to insured: ____________________

Insured's Date of Birth: _______________Insured's Social Security #: ____________________

Person Responsible For Payment, If Not Patient

Name: ______________________________ Relationship: ____________________ Home Phone: ________________

Mailing Address: ____

Date of Birth: ____________________ Soc. Sec. #: ______-________-________ Occupation: ____________

Employer: ____ Phone Number: ___________________

Mailing Address: ____

By signing this I understand that I am taking financial responsibility for the above named patient.

Signature: ____ Date: __________________________

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to the provider. I have verified that my insurance company has authorized services to the provider. I am financially responsible for any balance due, including failure to cancel my appointment with 24-hour advance notice (no show), copying fees, testing fees, other fees, etc.
Release: I hereby authorize the doctor and the insurance company to release information to one another as required only for this claim.

Signed: ____ Date ____________________

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company: ____

Claims Address: ____

Payer ID#: ______________________ Mental Health Benefits & Eligibility Phone Number: _____________________

Policy Holder's Name: ___________________________________ ID # ______________________ Group # __________

Patient's Name: _________________________________DOB: _________________ Date of Appointment: ___________

Date Insurance Company Called: __________________ Spoke to: ____

Does patient have outpatient mental health coverage? Y N Start Date _______________ End Date ________________

Pre-Auth Required? Y N Referral Required? Y N Any limit on visits? Y N If so, how many? ____________________

Calendar Year or Benefit Year (circle one) How many used? ___________________

Is there a deductible? Y N If so, how much? ___________________ Individual ___________Family_________________

Has deductible been met? Y N Coverage %? _______________________________ Co-Pay Amt.__________________

Co-Ins %________________________________ Authorization /Reference #__________________________________

Does primary forward info to secondary? Y N Authorized Procedure Codes: 90791, 90837, 90806

Other Limitations:__________________________________

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company: ____

Claims Address:____

Payer ID#: ________________________ Mental Health Benefits & Eligibility Phone Number: _____________________

Policy Holder's Name: ________________________________ ID # ______________________ Group # _____________

Patient's Name: _____________________________DOB: _________________ Date of Appointment: _______________

Date Insurance Company Called: __________________ Spoke to: ____

Does patient have outpatient mental health coverage? Y N Start Date _______________ End Date ________________

Pre-Auth Required? Y N Referral Required? Y N Any limit on visits? Y N If so, how many? _________

How many used? ______________ Calendar Year or Benefit Year (circle one)

Is there a deductible? Y N If so, how much? ___________________ Individual ___________ Family_______________

Has deductible been met? Y N Coverage %? ___________ Co-Pay Amt.______________Co-Ins %_____________

Authorization /Reference #_____________________________

Does primary forward info to secondary? Y N Authorized Procedure Codes: 90791, 90837, 90847, ______________

Exclusions/Limitations: ____

Instructions: Use this form when you call your insurance company to verify your eligibility and benefits for mental health or behavioral health services prior to your first visit. This information is needed to properly bill your insurance company. Remember, fees not covered by insurance are the responsibility of the patient and/or the account guarantor.