PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ Child / Adult (please circle)

Street: _____ City: _____

County: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Who referred you to our practice? _____

Person Responsible for Payment:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Person to Notify in Case of Emergency:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Signature on File Authorization:

I understand that payment is expected at the time of service. Otherwise, I hereby authorize payment of Medicare or other insurance benefits be made to Associates in Psychological Services, P.A. (APS) for services rendered to me by APS. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. If I am not in compliance with my insurance plan's procedures I will be responsible for the total balance of my bill. I will notify this office of any changes in my health status or changes in the information provided.

My signature below indicates that I have read the Psychologist-Patient Services Agreement and agree to its terms. My signature also serves as an acknowledgement that I have received information about HIPAA.

Signature: _____ Date: _____

Parent / Guardian signature (if minor): _____ Date: _____

********** For Office Use **********

Clinician: _____ Source: _____ Copy of Insurance Card Obtained: Y / N