PSY
PSYCHOLOGICAL
SERVICES, P.C.

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NEW PATIENT REGISTRATION

PATIENT'S NAME: _____ DOB: _____ AGE: _____
ADDRESS: _____CITY: _____ STATE/ZIP_____
HOME PHONE: _____ WORK #: _____ CELL #: _____
SS #: _____ SEX: ____M ____F MARITAL STATUS: ____S ____M ___ D ___W
REFERRED BY:_____ PRIMARY PHYSICIAN_____
OCCUPATION; _____ EMPLOYED BY: _____
SPOUSE'S NAME:_____ SPOUSE'S SS#: _____

IF PATIENT IS A MINOR, PLEASE FILL IN THE FOLLOWING AND ABOVE:

LEGAL GUARDIAN NAME:_____ DOB:_____
RELATIONSHIP TO PATIENT; _____ GUARDIAN SS#: _____
ADDRESS: _____ CITY:_____ STATE/ZIP:_____
HOME PHONE #:_____ CELL PHONE #: _____

NAME OF INSURANCE PLAN: _____ INSURED'S DOB: _____
INSURED'S NAME: _____ INSURED EMPLOYED BY: _____
RELATIONSHIP TO PATIENT: ___SELF ___SPOUSE ___PARENT ___OTHER
SUBSCRIBER ID#: _____ GROUP #: _____ COPAY: $_____

COMPLETE THE FOLLOWING *IF YOU ARE ALSO INSURED UNDER ANOTHER HEALTH CARE PLAN;*

NAME OF INSURANCE PLAN: _____
INSURED'S NAME; _____ ***DOB*** _____
RELATIONSHIP TO PATIENT: _____***SPOUSE*** _____***PARENT*** _____***OTHER SS #:*** _____
SUBSCRIBER #: _____ ***GROUP #:*** _____
EMPLOYED BY: _____ ***OCCUPATION:*** _____

I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, ASSIGN PAYMENT DIRECTLY TO **PSYCHOLOGICAL SERVICES, P.C.,** AND ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY UNPAID BALANCE. I, _____, ASSIGN ALL MEDICAL BENEFITS TO INCLUDE, BUT NOT LIMITED TO MVP, CDPHP, VALUE OPTIONS, BLUE SHIELD TO PSYCHOLOGICAL SERVICES, P.C.

SIGNED_____ DATE: _____
(PATIENT'S SIGNATURE OR GUARDIAN IF PATIENT IS UNDER 21)

PAYMENT OF MEDICARE BENEFITS:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS IS MADE EITHER TO ME, OR ON MY BEHALF, TO **PSYCHOLOGICAL SERVICES, P.C.** FOR SERVICES FURNISHED ME BY SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ DATE: _____
(INSURED OR AUTHORIZED PERSON'S SIGNATURE)

LIST ALL NAMES OF FAMILY, FRIENDS OR OTHERS THAT WE MAY DISCUSS YOUR PHI WITH (INCLUDE THOSE WHO MAY CALL ON YOUR BILL):

_____ _____
_____ _____