ADVANCED Psych Care

REGISTRATION

Patient Name_____
Last First Middle Initial

Social Security Number_____ Home Telephone_____

Street Address _____

City_____State_____ Zip Code_____

Sex_____Age_____ Date of Birth _____

Marital Status: ____ Single _____ Married ____ Widowed ____ Separated ___ Divorce __ Other

Patient Employed By: _____ Occupation _____

Work Address:_____ Work Telephone _____

Who referred you to this office? _____Emergency Contact & Phone # _____

INSURANCE INFORMATION

Person Responsible for the Account:_____
Last First M.I.

Relation to the Patient: _____Birthdate_____/ /____ SSN#_____

Address:_____Phone:_____
City State Zip

Insurance Company_____Business Phone:_____

Insurance Company Address:_____Contract#_____Group#_____

Names of other Dependents covered under this Plan_____Subscriber #_____

Copay Amounts$_____

Additional Insurance

Subscriber Name_____Relation to Patient_____Birthdate_____

Address (if different from patient)_____
City State Zip Phone

Employer_____Insurance Company_____
Insurance Company Address_____SSN#_____
Group#_____Contract#_____Subscriber#_____
Names of other dependents on Plan_____`_____Business Phone_____

Assignment and Release

I, the undersigned, certify that I, (or my dependent) have coverage with _____ and assign directly to ADVANCED Psych Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

Patient Signature_____ Minor Signature (12-17 years old)_____