Children First Psychiatry Patient Registration Form

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: AL Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Employer: _____ Social Security #: _____

Birth Date: _____ Age: _____ Gender: _____ Marital Status: _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____ Living Arrangement: _____

Responsible Party Information

Responsible Party is Patient: Yes No

First Name: _____ Last Name: _____ Relationship to Patient: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Financial and Policy Holder Information

Primary Insurance:

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Secondary Insurance: Yes No

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

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Tertiary Insurance (If Applicable):

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Telephone #: _____ Sex: M or F

Authorization to Release Information: The undersigned authorizes _____ and any physician rendering service to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative or anyone responsible for payment of services.

Authorization to Release Information to Referring Physician: I hereby authorize **Annie A. Keriotis, M.D**. to release information concerning my treatment to the referring physician.

Assignment of Benefits: The undersigned assigns to and authorizes direct payment of benefits (including insurance benefits, otherwise payable with respect to the patient) to **Annie A. Keriotis, M.D**. The undersigned agrees to assist in processing claims for benefits.

Financial Responsibility: In consideration of the services provided or to be provided, the undersigned agrees to pay **Annie A. Keriotis, M.D**. for the services rendered or to be rendered to above-said at the time of visit. In failing to do so, I hereby waive all claims or rights to exemption and agree to pay the reasonable cost of collection, including a reasonable attorney's fee for the collection of the account if assigned to an attorney for collection. Additional fee of $35 will be incurred by payee for returned check payments.

I acknowledge that I have read this form and understand its purpose and content.

_____ _____

Guarantor (Agreement to Pay) Patient (or authorized Representative/Relationship to Patient)

_____ _____

Date Date