

# SAMANTHA MCGANN, LCSW

## PATIENT REGISTRATION SHEET

Today's Date:		Provider:			
<b>PATIENT INFORMATION</b>					
Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
				Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street Address:		City:		State:	ZIP Code:
Home phone no.: (    )		Cell/Other contact no.: (    )		Social Security no.:	Birth Date: / /
				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Employer:			Occupation:		Work phone no.: (    )
Street Address:		City:		State:	ZIP Code:
Referring Doctor (if required by insurance):					
Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO		Name of Primary Care Physician			Contact no.: (    )
<b>IN CASE OF EMERGENCY</b>					
Emergency Contact Name:		Home phone no.: (    )		Cell phone no.: (    )	
<b>INSURANCE INFORMATION</b>					
Insured's Last Name (if different):		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
				Marital status (circle one) Single / Mar / Div / Sep / Wid	
Home phone no.: (if different) (    )		Cell/Other contact no.: (    )		Social Security no.:	Birth Date: / /
				Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Insurance Company:		Insurance Billing Address:			Insurance phone no.: (    )
Policy no.:		Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<b>SECONDARY INSURANCE INFORMATION (IF APPLICABLE)</b>					
Insurance Company:		Insurance Billing Address:			Insurance phone no.: (    )
Policy no.:		Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Samantha McGann, LCSW, Dr. Kimberly A. Lemke P.C., Mary Englund , PsyD, LLC, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.</p> <p>Furthermore, I have reviewed the Notice of Privacy Practices &amp; the Professional Service Agreement provided. I fully understand and accept the terms of this practice.</p>					
_____				_____	
<i>Patient/Guardian signature</i>				<i>Date</i>	

**\* PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**