PATIENT REGISTRATION FORM

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

Address: _____ City: _____ St: _____ Zip: _____

Home Telephone #: _____ Alternate Telephone #: _____

Date of Birth: _____/_____/_____ Social Security No.: _____-_____-_____ Sex: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other: _____ Age: _____

Responsible Party: _____ Email address: _____

Relationship to patient: _____ Occupation: _____ Work Telephone: _____

Employer: _____Email: _____

Patients Spouse or Parent (If Minor): _____ Telephone #: _____

Emergency Contact: _____ Telephone #: _____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to ___TherapyCulture LLC____for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize Clear Solutions, LLC (contracted billing service for _TherapyCulture LLC_) to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Clear Solutions, LLC to sign said claim(s) or any refiled claim on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: _____ Signature: _____ Date: _____

Insurance Information

Company Name: _____ Telephone #: _____Policy No.: _____

Group No.: _____ Policy Holder's Social Securtiy No. (if different from Patient): _____-_____-_____

Policy Holder (if different from Patient): _____ Relationship: _____

TO BE COMPLETED BY BILLING OFFICE

Date:_____ Spoke with: _____ Circle one: In Network Out of Network

Policy Effective: _____ Co pay Per Visit: $_____ Coinsurance Per Visit: _____

Deductible Amount: $_____ Deductible Met: $_____ Max Visits/Max Payable Per Year: _____

Out of Pocket Max Per Year: _____ Exclusions to policy: _____

Claims Address: _____ City: _____ St: _____ Zip: _____

Authorization #: _____ Sessions Approved: ____ Authorization Date: _____ thru _____

Notes: _____
