REGISTRATION FORM

(Please Print and Complete ALL Applicable Sections)

Date : _____

PATIENT INFORMATION

NAME _____
LAST *FIRST* *MIDDLE*

DATE OF BIRTH _____ SEX ☐ M ☐ F MARITAL STATUS_____ SOCIAL SECURITY # _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

PREFERRED PHONE NUMBER (_____)_____ ALTERNATE PHONE NUMBER (_____)_____

EMAIL ID _____ AGE_____

EMERGENCY CONTACT NAME _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE NUMBER _____ PHARMACY NUMBER _____

RACE/ETHNICITY *(OPTIONAL)* _____

PCP NAME _____ PHONE : (_____)_____

THERAPIST NAME _____ PHONE: (_____)_____

CURRENT OCCUPATION _____

EMPLOYER /SCHOOL NAME AND ADDRESS_____

_____

REFERRED BY: ☐ FRIEND ☐ FAMILY
☐ PCP THERAPIST ☐ INSURANCE WEBSITE
☐ INTERNET

INSURANCE INFORMATION

PRIMARY INSURANCE NAME AND ADDRESS_____

MEMBER ID NUMBER _____ GROUP NUMBER _____

Secondary Insurance: ☐ YES ☐ NO Secondary Insurance name and ID _____

Subscriber or policy holder's Name _____

Subscriber DOB _____ Subscriber Phone number (_____)_____

Subscriber address_____

Subscriber Social security number _____

Subscriber Employer name and address _____

Patient's relationship to subscriber:_____

***Please Note** We will collect Primary Insurance Copayments as these are typically not covered by secondary insurance**

PLEASE READ AND SIGN ALL SECTIONS

CONSENT FOR TREATMENT AUTHORIZATION

I authorize and request my Psychiatrist to carry out psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my Psychiatrist can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my Psychiatrist and me. With these understandings, I hereby authorize treatment for myself. I give permission for my psychiatrist to develop a treatment plan and provide treatment.

Signature of Patient/Guardian **Date**

AUTHORIZATION TO RELEASE INFORMATION TO PCP

Communication between Psychiatrist and your primary care physician is important to ensure that you receive comprehensive and quality care. I hereby authorize release of my protected health information which may include mental health diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time, except to the extent that it has been relied upon.

Signature of Patient/Guardian **Date**

MISSED OR LATE CANCELLED APPOINTMENT

I agree to make every effort to give 48 hour advance notice for all appointment cancellations or reschedules. I understand that my account will be charged a $50 missed fee for any missed or cancelled appointments without 48 hour advance notice. I agree to pay any fees charged to my account for this reason by my next scheduled appointment. I understand this charge is not a co-pay amount and is not reimbursable by my insurance. I understand that after continued missed appointments, I may be dismissed from the practice.

Signature of Patient/Guardian **Date**

AUTHORIZATION FOR INSURANCE SUBMISSION,PAYMENT & RELEASE OF INFORMATION

The information completed is true to the best of my knowledge. I certify that I, and/or my dependent(s)have insurance coverage with listed insurance and authorize payment directly to SUNITA GUPTA MDPC of 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, and for all services rendered on my behalf or my dependents. The above named physician may use my healthcare information and may disclose such information to the Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand that I am responsible for ensuring Authorization for services has been obtained as required by my insurance company. I agree to pay all deductible, coinsurance, and/or copayments at the time services are rendered. I further understand that payment for services by my insurance company is contingent upon my benefit and coverage details and final determination of my responsible charges is made after my insurance has processed the claim. I authorize the use of my signature on all insurance submissions.

Signature of Patient/Guardian **Date**

CONSENT FOR USE DISCLOSURE OF HEALTHCARE INFORMATION

My signature below indicates that I have been given the chance to review a current copy of Notice of Privacy Practices .My signature means that I agreed to allow my provider to use and disclose the personal health information to carry out treatment payment and healthcare operations.

Signature of Patient/Guardian **Date**