Pediatric Psychological Services

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PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Child's Name_____
First Middle Last

Age_____ Date of Birth ___/___/_____ Place of Birth_____
(mm/dd/yyyy) City/US State/Country

Home Street Address_____

City_____State_____Zip_____

Home Phone _____ Cell Phone _____

Email _____

PRIMARY INSURANCE:

Person responsible for account _____
First Middle Last

Relationship to Patient_____ Subscriber's Date of Birth ___/___/_____

Address_____
(if different than patient's)

City_____State_____Zip_____

Subscriber Employed By _____

Employer's Address_____

City_____State_____Zip_____

Insurance Co._____

Group #_____ Member #_____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____. I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and copayments, in addition to payment for any services of treatment not covered by my insurance carrier. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to Pediatric Psychological Services. I authorized the release of any payment and medical information necessary to process my or my family member's insurance claim and related claims. I hereby authorize payment directly to Pediatric Psychological Services of the insurance benefits otherwise payable to me for all professional services.

_____	_____	_____
Parent or Guardian Signature	Print	Date