# REGISTRATION FORM

Name: ______________________________________________

*Last Name* *First Name* *Middle Initial*

Age: ________ Date of Birth: _______ School: ______________________ Grade: __________

Parents: ______________________________________________
Street Address: ______________________________________________
City: ____________________ State: __________ Zip: ____________
Home Phone: ____________________
Parent Contact: Cell Phone________________ Email: ____________________ (Parent: ________)
Cell Phone________________ Email: ____________________ (Parent: ________)

*For Adolescents and Young Adults:*
Patient Contact: Cell Phone________________ Email: ____________________

Referred By: ______________________________
Current Medications: ______________________________

**Medical Insurance Company Name:**______________________________

Many insurance plans provide coverage for psychological services. It is your responsibility to call to obtain information about your coverage and any authorization requirements. I am glad to complete treatment plans if provided with the information below:

Subscriber Name: ______________________________ Date of Birth: ________________
Membership #: ______________________________ Group #: ________________
Did you call for preauthorization: ❑Yes ❑No Date of Call: ________ Authorization #: ____________
Treatment Plan Needed? ❑Yes ❑No When? ________ Fax # for Treatment Plan: ________________

| Current Providers | | |
|---|---|---|
| | Name | Phone Number |
| Pediatrician | | |
| Psychiatrist | | |
| Psychologist/Therapist | | |
| School Counselor (if involved) | | |
| Medical or Educational Specialist | | |

Bills are provided at the end of each appointment. Patients and families pay for services directly, send in their own bills and are reimbursed by their insurance company for their portion. Please be aware that insurance companies vary in their reimbursement for mental health services and no amount of reimbursement is guaranteed.

- Payments for diagnostic evaluation, consultation, psychotherapy, and psychological testing are due at the time of the appointments.
- Other professional services including the preparation of letters and attendance at school or other meetings are billed on an hourly basis and due within the same month as the service is provided.

By your signature below, you are indicating that you have read, understand and agree to the financial policies, and allow for the release of clinical information needed by your insurance company for authorization of clinical services.

______________________________ ________________

*Signature of Parent/Guardian/Person Responsible for Account* *Date*