VILLAGE FAMILY PSYCHIATRY, PLLC

PATIENT REGISTRATION FORM

Date _____/____/_____

Name ____ Sex _________ Appointment with: _______________________
(First) (Middle) (Last) M.D./Therapist

Address ____ City ____________________ State ______ Zip Code _______

Home Phone (____)_______________ Cell Phone (____)________________ Marital Status ___M ___S ___D ___P ___W

Date of Birth ____/____/____ Age ______ Social Security # ______-_____-________ Occupation ______________________

Employer/School_______________________________Address _____________________________City____________________

State _______ Zip Code _____________ Phone (_____)_______________ext_______ Full-time _______ Part-time ________

Name of Spouse (Parent if patient is a minor) ____ Phone (____)_______________

Person to contact in case of Emergency _______________________________ Relationship __________ Phone (___)_________

Name of Primary Care Physician ____ Phone (_____)_____________

INSURANCE INFORMATION: If you are being seen due to a Workers' Compensation Injury, list the carrier in the Primary area

Primary Insurance ___________________________________ Policy # _____________________ Group # ________________

Address ____________________________ City _________________ State _____ Zip ___________ Phone(___)___________

Subscriber Name ________________________________ Relationship _______________ Date of Birth ______/______/______

Subscriber's Soc Sec # _______-______-__________ Employer____

Secondary Insurance ___________________________________ Policy # _____________________ Group # ________________

Address ____________________________ City _________________ State ______ Zip __________ Phone (___)___________

Subscriber Name _________________________________ Relationship _______________ Date of Birth ______/______/______

Subscriber's Soc Sec # ________-______-__________ Employer____

If you have Medicare and other coverage through another person, we MUST have the following:

Subscriber's Date of Birth ___/___/___ Sex ______ Is Subscriber a student? ____ yes ____ no, If yes full-time? ___________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS*:*

Check one of the following:
_____ Do not file a claim for me
_____ File a claim for me, I authorize payment of medical benefits directly to: Village Family Psychiatry, PLLC
I hereby authorize the release of any medical information to the insurance company(ies) listed above in order to process any claim(s). I further authorize copies of this authorization to serve in place of an original. I understand that I am financially responsible for charges not covered by this authorization as well as any balance not paid by insurance including services not covered due to my failure to obtain an authorization from my insurance carrier and /or PCP if needed or not covered under the terms of my policy.
I acknowledge that I have received a copy of the General Policies of Village Family Psychiatry, PLLC, and agree to the terms and conditions of these policies to include payment for missed appointments or if 24-hour cancellation notice is not given to cancel an appointment. (Please note that insurance companies do not pay for any portion of the charge for a late cancellation or missed appointment.) If my account is turned over to an attorney for collection, I will be responsible for attorney fees in the amount of thirty-five percent (35%) of the total debt plus court costs and interest at the rate of 1.5% per month on the unpaid balance from the date that payment was first due.

Signature of Patient/Legal Guardian ____ Date ________________________

Signature of Witness____ Date ________________________