ClearInsight Psychiatry, Inc.
PATIENT REGISTRATION INFORMATION

Name:__________________________ Date of Birth:___/___/____ Sex: Male• Female•
Home Address:____
City:_____________________________ State:_______ Zip Code:_________________
Home Telephone: (   )____________Work Telephone: (   )__________________
Cell Phone:(   )______________E-Mail Address:_______________________________
Employer:__________________________________Occupation:____________________
Primary Care Physician:____
Referring Physician/Psychologist/Therapist:_______________________________________
How did you hear about us: Internet• ad • others•
Preferred Pharmacy Name, Location, Phone if known:_____________________________

Emergency Information
Name of Emergency Contact:____________________ Relationship to Patient:________
Emergency Telephone (   )______________

Insurance Information
Primary Insurance: ________________________Social Security Number:___________
Subscriber Name:________________________ Date of Birth:____/___/_______
Group Number: ___________________Identification Number:______________________
Secondary Insurance: ______________________Social Security Number:____________
Subscriber Name: _________________________Date of Birth:____/____/_______
Group Number: ____________________Identification Number:___________________

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment to ClearInsight Psychiatry, Inc of any medical benefits payable to me for services provided at ClearInsight Psychiatry, Inc. I also understand that it is my responsibility to obtain my required referral authorization prior to my appointment time. I am also responsible for any co-payment, deductible, or patient portion on the day of service. I understand that if my account becomes delinquent, I will be held responsible for reasonable attorney's fees, court costs, and collection costs.

MEDICAL RECORDS RELEASE

I hereby authorize ClearInsight Psychiatry, Inc. to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

*Patient Signature____Date:________

For Office Use Only

CURES:_____Copay: $_____Insurance Name:_________ Authorization/Visit:________