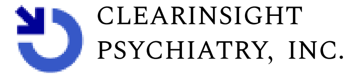
PATIENT REGISTRATION FORM



PATIENT DEMOGRAPHICS

Name:_________________________ Date of Birth:___/___/______ Sex: ❑ Male ❑ Female

Home Address:____
City State Zip

Cell Phone: ( ) _____________________ Home Phone: ( ) _____________________

Email Address:___________________________ Occupation:___________________________

Emergency Contact Name:_________________________ Relationship to Patient:_________

Emergency Phone: ( ) _____________________ ROI Consent: ❑ No ❑ Yes

Primary Care Physician:_________________________ Source of Referral:________________

Preferred Pharmacy Name and Address:____

INSURANCE INFORMATION

Primary Insurance:_____________________ Subscriber SSN:_________________________

Subscriber Name:_________________________ ❑ Self ❑ Spouse ❑ Parent ❑ Other

Member ID:________________ Group:________________ Subscriber DOB:___/___/______

Secondary Insurance:___________________ Subscriber SSN:_________________________

Subscriber Name:_________________________ ❑ Self ❑ Spouse ❑ Parent ❑ Other

Member ID:________________ Group:________________ Subscriber DOB:___/___/______

ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to ClearInsight Psychiatry Inc. for services rendered. I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I understand that if my account becomes delinquent, I will be held responsible for attorney fees, court costs, and collection costs.

MEDICAL RECORD RELEASE

I authorize ClearInsight Psychiatry Inc. to release pertinent medical information to my insurance company upon request, or to facilitate payment of a claim. The authorization remains in effect as long as outstanding charges are being submitted for insurance claim processing.

Patient Signature:____ **Date:**______________

Office Use Only: **CURES:** ❑ No ❑ Yes **Copay:** $__________