

REGISTRATION INFORMATION

(Please Print)

PATIENT'S INFORMATION

Today's Date: _____
Last Name: _____ First Name: _____ MI: _____ Suffix: _____
D.O.B.: _____ Marital status: _____ Age: _____ Sex: _____ SS#: _____ DL#: _____
Address : _____ City/State/Zip: _____
Home Phone: _____ Work Phone: _____ EXT: _____ Cell Phone: _____
In case of an emergency, who should be notified: _____ Relationship: _____
Phone: _____ How did you learn of our practice? _____
Name of PCP: _____ Name of Physician Referred by: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Relationship to Patient: _____ Name: _____ DOB: _____
Address: _____ City/State/Zip _____ Phone: _____

_____ DO NOT FILE WITH MY INSURANCE COMPANY _____ FILE WITH MY INSURANCE COMPANY
(initial) (initial)

ALL OF THIS INFORMATION IS NEEDED IF FILING INSURANCE, PLEASE FILL OUT ENTIRELY

PRIMARY INSURANCE: _____

Policy Holder's: _____ Policy Holder's D.O.B. _____
Policy #: _____ Group #: _____ Policy Holder's SS #: _____ Start Date: _____
Policy Holder's Address: _____ City/State/Zip: _____
Employer insurance plan: _____ Yes _____ No
Employed By: _____ Occupation: _____

SECONDARY INSURANCE: _____

Policy Holder's Name: _____ Policy Holder's D.O.B. _____
Policy #: _____ Group #: _____ Policy Holder's SS #: _____ Start Date: _____
Policy Holder's Address: _____ City/State/Zip: _____
Employer insurance plan: _____ Yes _____ No
Employed By: _____ Occupation: _____

Cancellations must be called in 24 hours in advance or the account will be billed

ASSIGNMENT OF BENEFITS . FINANCIAL AGREEMENT

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of insured) (Name of insurance company)

to pay and hereby assign directly to Clinical Associates, P.A. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred whether or not they are covered or deemed not to be of medical necessity by my insurance provider. I further acknowledge that any insurance benefits, when received by and paid to Clinical Associates, P.A. will be credited to my account, in accordance with the above said assignment.

(Signature of Responsible Party)

(Date)