PATIENT REGISTRATION FORM

Patient Name: ______________________________________ Social Security Number: ______-_____-_______

Date of Birth: ________/_____/________ Sex: M / F (circle one) Married / Single / Divorced / Widow

Address: ____

(Street) (City/State/Zip)

Home Phone: (_____)______-___________ Email Address: ____

Would you be interested in having communications sent to you via your email address? Yes No

Employer Name: ____________________________________ Employer Phone Number: (____)_____-_______

Primary Care Physician: ____ Copay Amount: $_______

How did you hear about our Practice? ____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: __________________________________ Social Security Number: ______-_____-_______

Relationship to Patient: (please check): ( )self, ( )spouse, or ( )parent Date of Birth: _____/___/______

Address: ____ Phone Number: _______________

Employer Name: ____ Employer Phone Number: (__)____-______

Who to call for an emergency:

Name: _________________________________ Address: ____

Home Phone: (____)_____-_______ Work Phone: (____)_____-_______ Relationship: ___________________

FIRST INSURANCE INFORMATION:

Plan Name: ______________________________________ I.D. Number: _______________________________

Address: ____ Group Number: _____________________________

Policy Holder: ____________________________________ Effective Date: ______________________________

Policy Holder's Social Security Number: _______________-________________-_________________

Policy Holder's Date of Birth: ________/_____/________ Sex: M / F

SECOND INSURANCE INFORMATION:

Plan Name: ______________________________________ I.D. Number: _______________________________

Address: ____ Group Number: _____________________________

Policy Holder: ____________________________________ Effective Date: ______________________________

Policy Holder's Social Security Number: _______________-________________-_________________

Policy Holder's Date of Birth: ________/_____/________ Sex: M / F

Informed Consent for Treatment

I ___________________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _________________________(name of provider), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Michael Loftis, LCSW. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _________________________________ Date: ____________________