PATIENT REGISTRATION

OFFICE USE ONLY

PCN ____________ DR# ____________

CHECK ONE ☐ CA ☐ INS ☐ D\COV ☐ I\O ☐ HMO ☐ VW

DX:__________ FEE $ ________ W/O $ _________

Please Print — PATIENT INFORMATION — Please Complete Entire Section

PATIENT: ______________________________________ DATE OF BIRTH: ______ / ______ / ______ SEX: M ☐ F ☐
(Last Name) (First Name) (Middle Initial) (Month) (Day) (Year) (Male) (Female)

ADDRESS: ______________________________________ (________) -________________
(Number) (Street) (Apt #) (City) (State) (Zip Code) (Area Code) (Number)

SOCIAL SECURITY#: ______ / _____ / _________ OCCUPATION: ________________ MARITAL STATUS: ☐ ☐ ☐ ☐
(Married) (Single) (Divorced) (Widowed)

EMPLOYER INFORMATION:______________________________ (________) -________________
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

FAMILY PHYSICIAN: ______________________________ (________) -________________
(Last) (First) (Area Code) (Number)

PATIENT WAS REFERRED/AUTHORIZED BY: ______________________________ (________) - ________________
(Area Code) (Number)

Please Complete Entire Section — RESPONSIBLE PARTY — Please Print

RELATIONSHIP TO PATIENT: (Please check the appropriate box) SELF [ ] SPOUSE [ ] PARENT [ ] OTHER [ ]

GUARANTOR:______________________________ SOCIAL SECURITY#: ______ / _____ / _________
(Last Name) (First Name) (Middle Initial)

ADDRESS: ______________________________ (________) - ________________
(Number) (Street) (Apt #) (City) (State) (Zip Code) (Area Code) (Number)

EMPLOYER INFORMATION:______________________________ (________) - ________________
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

Please Complete Entire Section — INSURANCE INFORMATION — Please Print

PRIMARY INSURANCE: ______________________________ (________) - ________________
(Area Code) (Number)

INSURED'S NAME: ______________________________ RELATION TO PATIENT: ☐ ☐ ☐ ☐
(Last) (First) (Middle Initial) (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ______ / ______ / ______ INSURED'S SS# : ______ / _____ / _________ GROUP/PLAN# : ________________
(Month) (Day) (Year)

EMPLOYER INFORMATION:______________________________ (________) - ________________
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

SECONDARY INSURANCE: ______________________________ (________) - ________________
(Area Code) (Number)

INSURED'S NAME: ______________________________ RELATION TO PATIENT: ☐ ☐ ☐ ☐
(Last) (First) (Middle Initial) (Self) (Spouse) (Child) (Other)

INSURED'S DATE OF BIRTH: ______ / ______ / ______ INSURED'S SS# : ______ / _____ / _________ GROUP/PLAN# : ________________
(Month) (Day) (Year)

EMPLOYER INFORMATION:______________________________ (________) - ________________
(Name) (Address) (City) (State) (Zip) (Area Code) (Number)

Required Section — ASSIGNMENT OF BENEFITS / TREATMENT AUTHORIZATION AND RELEASE

NAME OF DOCTOR/THERAPIST(PROVIDER): __Jason P. Springsted, LMFT________________

I hereby authorize treatment of the above mentioned PATIENT and further authorize PROVIDER to release such information including diagnosis to my referring physician as well as that which may be required to process any insurance claims covering my treatment. In addition, I hereby authorize direct payment, to the above named provider, the benefits to which I may be entitled by my insurance carrier. I also understand that I am **RESPONSIBLE** for any **OUTSTANDING BALANCE DUE** on my account.

I understand that the above mentioned PROVIDER must receive 24 hours notice of cancellation for any appointments which have been scheduled. If you fail to notify the above mentioned provider before the 24 hour period you may be charged up to the full professional fee.

Signature______________________________ **Date**____________________