Psychological

Health Associates Date ____________________

Registration Form

Patient Information:

Name: ____

Patient Address: ____
Street City/State Zip code

Phone: Cell: ________________Work: __________________ Home/preferred: ________________

I understand that by providing numbers above, I am giving consent that I may be contacted with "call back" information only.

Date of Birth: ___________ Gender/Preferred Pronoun: ___ Male (he/him) ___ Female(she/her) ___ Other

Email: ______________________ Marital/Partner Status: _______________________________
(necessary for telehealth) eg: single, unmarried partner, married, divorced, widowed

Partner/Spouse/Parent Name:____

Emergency Contact:

Name: _______________________________ Relationship: _____________________________

Phone: Cell: ______________ Work: _______________ Home:___________________________

Address: ____

Responsible Party (Person to whom bills will be sent)

Self: _______ or Other/Name: ____

Relationship to Patient: ____________________ Phone: ________________________________

Address: ____

Insurance Information:

Insurance Company: ___________________________ Phone Number: ____________________

Name of Insured: _________________________ ID#: ___________________ Group#: _________

Insured's DOB: ______________ Insured's Last 4 Social Security Numbers: _____________

Your Physicians: Primary Care: ______________ Gynecologist: ____________ Other: ____________

How did you hear about our practice? _______________________________________

I hereby authorize PHA to release all information required to obtain authorization for treatment and to process insurance claims. I further authorize payment directly to PHA for benefits due me for services rendered. I understand I am financially responsible for charges not covered by insurance (in accordance with my benefit plan), including any applicable deductibles or copayments. I further understand I am responsible for fees for broken appointments or cancellations without 24 hours notice. I understand that I will be charged interest on any outstanding balance past 30 days at a rate of 1.5% per month, 18% yearly.

_______________________________ _________________________

Patient or Authorized Signature Date

FOR OFFICE USE ONLY

DX ______ _______ Referred by ___________________ PHA Therapist___________________________