PATIENT REGISTRATION

(New: ☐ Change: ☐)

_____
(Change date)

Email Address: _____

Name:..... _____ _____ _____
Last First Middle

Street Address:.. _____ **Work Tele. # (Or Parents'):** _____

City:..... _____ **Home Tele. #:**. _____

State:..... _____ **Birth Date:**..... _____/_____/_____

Zip Code:..... _____ **Sex:**..... **MALE** ☐ **FEMALE** ☐

Marital Status:... **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED** ☐

Employment: EMPLOYED ☐ **UNEMPLOYED** ☐ **FULL-STUDENT** ☐ **PART-STUDENT** ☐

Primary Physician & City:..... _____
How were you referred here?..... _____
If hospitalized: Name of hospital: _____ **Date:** _____ **Physician:** _____

(Please complete All insurance items below if you want us to file for you.)

	INSURANCE (First Policy)	INSURANCE (Second Policy)
Insurance COMPANY Name:	_____	_____
Insurance POLICY Name:.....	_____	_____
Ins. Street Address:.....	_____	_____
Ins. City, State, Zip:.....	_____	_____
Ins.Telephone Number:.....	_____	_____
Insured's Name:.....	_____	_____
Insured's Street Address:.....	_____	_____
" City, State, Zip Code:....	_____	_____
Insured's Date of Birth:.....	_____/_____/_____	_____/_____/_____
Insured's Sex:.....	**MALE** ☐ **FEMALE** ☐	**MALE** ☐ **FEMALE** ☐
Insured's SS or ID Number:...	_____	_____
Group Number or Name:.....	_____	_____
Patient's Relationship To Insured:	**SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ☐	**SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** ☐

(Reverse side is for office use only)

(This side for office use only)

	First Policy:	Second Policy:
Policy Type:	**Group☐ Other ☐ Champus☐ Medicare ☐ Medicaid ☐**	**Group☐ Other☐ Champus☐ Medicare ☐ Medicaid ☐**
Prior Authorization Number:	_____	_____
Therapist Provider Number:	_____	_____
Patient Account Number:	_____	_____
Medicaid Resubmission Code:	_____	_____
Original Medicaid Reference #:	_____	_____

Carolina Access #:_____ **Referring Physician:**_____

Accept Assignment:	**YES☐**	**NO☐**	**YES☐**	**NO☐**

Therapist(s): _____

Date of First Consultation: _____/_____/_____

Diagnosis 1: _____

Diagnosis 2: _____

PAYMENT PLAN (check):

A ☐ Patient pays full or reduced fee each session; uses event tickets to file for insurance themselves.

B ☐ Patient pays in full or pays uninsured portion each session. Center files insurance to be paid to Center. (Signature on file)

C ☐ Patient billed at end of month. Center files insurance to be paid to patient.

D ☐ Patient or ☐ Company billed. No insurance filed. Purchase order # :_____

E ☐ Patient pays full or reduced fee each session. Center files insurance to be paid to patient.

F ☐ Patient is billed at end of month. Center files insurance to be paid to Center.

Z ☐ Other payment plan:

Special Instructions:

_____

_____