Center for Emotional Health & Wellness, LLC
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NEW PATIENT REGISTRATION & INSURANCE INFORMATION FORM

Patient Information (Who is Receiving Services?):

Full Name: ____
Address: ____
City: ____________________State _____ Zip ____________
Phone (Home)________________(Cell) ____________________
Work ________________ Email __________________________
Date of Birth: ______________________ Age: ____________
Marital Status ______________________________ _________
Patient Social Security #: ________________________________
Patient Driver's License #: _______________________________
School: Full/Part-time:___________________________________
Employment: Full/Part-time: _____________________________
Employer/Occupation: ____________________________________
Employer Address:____
Employer Phone: ____
Referred By: ____
Phone/Address: ____

Account / Guarantor Information(Who is Paying for Services?):

Name: ____
Address: ____
City: ___________________State ______ Zip _____________
Phone (Home) ________________(Cell) ___________________
Work ________________ Email ___________________________
Guarantor Date of Birth:__________________ Age: __________
Relationship to Patient: _________________________________
Guarantor Social Security #: ______________________________
Guarantor Driver's License #: _____________________________
Employment: Full/Part-time: _______________________________
Employer/Occupation: ____________________________________
Employer Address: _______________________________________
Employer Phone: ____
Emergency Contact: _______________________________________

PAYMENT AND INSURANCE INFORMATION

Insurance Company Name: ____
Office Visit Co-pay Amount: __________________________ Deductible Amount: ______________
Address: ____
Phone #: ________________________________ Email______________________________________
Policyholder Name & Address (if different from above): ___________________________________
Date of Birth: ________________________ Relationship to Patient:________________________
Employer:____
Member ID #:_________________________________ Group #: _________________________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services. I request that you file insurance claims for the services rendered, and will provide all necessary information for you to do so. **YES**__________ **NO** ___________

ASSIGNMENT OF BENEFITS: I Hereby authorize payment of benefits be made directly to the Practitioner for services provided to me by the Practitioner. I understand that I am financially responsible to the Practitioner for charges not covered by this assignment. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees. **YES**__________ **NO** ___________

BY SIGNING BELOW, I AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR ALL CHARGES INCURRED BY THEABOVE PATIENT.

____ _____________________________________
Signature of Patient (*If minor, signature of responsible person*) Date Witness Date