

PATIENT REGISTRATION

(New: Change:)

(Change date)

Name:.....
Last First Middle

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

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

State:..... Birth Date:.... / /

Zip Code:..... Sex:..... MALE FEMALE

E-Mail address: _____

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 SELF SPOUSE CHILD
OTHER 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:

