

REGISTRATION FORM

Please fill out this entire form.

Date: _____

Patient Information-PLEASE PRINT

Last Name _____ First Name _____ MI _____
 Sex: Male _____ Female _____ Nickname _____ Primary insured, please circle: Yes No
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____ Work Phone () _____
 Email address _____
 Date of Birth _____ Social Security # _____
 Marital Status: Married _____ Single _____ Separated _____ Divorced _____ Widowed _____
 Student Status: Full Time _____ Part Time _____ School _____ Not a Student _____
 Employment: Full Time _____ Part Time _____ Employer Name _____ Not working _____

Patient Information-PLEASE PRINT

Last Name _____ First Name _____ MI _____
 Sex: Male _____ Female _____ Nickname _____ Primary insured, please circle: Yes No
 Street Address _____
 City _____ State _____ Zip _____
 Home Phone () _____ Cell Phone () _____ Work Phone () _____
 Email address _____
 Date of Birth _____ Social Security # _____

Name & address of person responsible for co-pays and/or deductibles: _____

Primary Insurance Coverage **PLEASE DO NOT LEAVE ANY BLANKS** **PLEASE PRINT**

Insurance company _____ Managed Care Company _____
 Claims Address _____ City _____ State _____ Zip _____
 Policy# _____ Group# _____ Tel#() _____
 Is precertification/authorization necessary? _____ (if not sure you need to call your carrier for protocol)
 If Yes, Certification/Authorization# _____ #of visits _____ Start _____ End _____
 Name of Policyholder _____ (Must match to policy# above) Relationship to client _____
 Address of Policyholder _____ City _____ State _____ Zip _____
 Policyholder's Date of Birth _____ (required) Home # _____ Work# _____
 Policyholder's Social Security # _____

Please present your card to therapist to be photocopied.

Assignment and Release

I, the undersigned certify that I (or my dependent) has insurance coverage stated above and assign payment directly to entity named above all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance. I am entitled to a copy of this agreement by requesting same.

 Responsible Party Signature Relationship Date
 DATE OF FIRST VISIT _____
 Office use only: DX _____

CANCELLATIONS:

Please give 24 hours notice if you need to cancel an appointment. You will be charged for appointments you fail to keep, or for appointments not cancelled within 24 hours unless the situation is agreed upon as unavoidable by both of us. If you do not give notice you will be charged your regular fee. If you have insurance you will be charged out of pocket for the regular fee.

I acknowledge that I have read and agree to the above stated cancellation policy.

Client Signature (s)

Date

Shelley Fields, M.A., LMFT

Notice to Persons Regarding My Privacy Practices

This initial contact with you gives us an opportunity to discuss confidentiality and privacy issues. These practices are designed to protect your individual identifiable information and confidentiality. Although I am legally required to tell you about my privacy practices, I also believe that telling you about confidentiality is the right thing to do.

After we have discussed my privacy and confidentiality practices, I will give you a printed copy of my Notice of Privacy Practices if you request. The printed Notice of Privacy Practices outlines how I can use and disclose information along with the rights that you have regarding your information maintained by me. You can also download a copy from my website: www.sfieldstherapy.com.

Also, I must obtain written acknowledgement that I have discussed my privacy practices with you. By signing this form, you are only acknowledging that you have been informed about my practices to maintain privacy and confidentiality. Please indicate if you want a copy of the Notice of Privacy Practices.

If you have any questions, please don't hesitate to ask me. If you believe your rights have been violated or have a complaint about my practice, you may speak to me about it or contact the Secretary, Department of Health and Human Services.

By signing this document I am acknowledging that I have been informed about how my privacy and confidentiality will be maintained by Shelley Fields, M.A., LMFT.

Client Signature (s)

Date

Person Providing Notice

Date