Patient Registration – Adult

T. Michael Knack, Ph.D.

Date: _____

Patient Name: _____

Date of Birth ____/____/_____ Male ___ Female ___ Marital Status: S M D W

Address:_____City:_____ZipCode:_____

Phone: cell #: _____ work #: _____

Patient's Employer: _____ Employer Phone# : _____

Primary Care Physician:_____City:_____Phone_____

Food/ Drug
Allergies:_____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Employer:_____

Subscriber: _____ Date of Birth: _____

Contract/Policy #: _____ Social Sec # _____

Group/Plan #: _____

Secondary Ins.

Subscriber: _____ Date of Birth: _____

Contract/Policy #: _____ Social Sec # _____

Group/Plan #: _____

Insurance Authorization: I hereby authorize Dr. Knack to furnish information to my insurance carriers concerning my diagnosis and treatment, and I hereby assign to the psychologist all payments for services rendered to dependents or myself. I understand that I am responsible for any amount not covered by insurance.

HIPAA: I have read the HIPAA office policies. They are posted in office and on the website _____(initial)

Date: _____ Signature: _____

Witness: _____