Patient Registration – Adult

Kelly M. Baskind,

Ph.D. Date: _____

Patient Name: _____

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

Address: _____ City: _____Zip Code: _____

Telephone: Cell #:_____Home# :_____

Patient's Employer: _____ Employer Phone #: _____

Primary Care Physician: _____ City: _____Phone_____

Food/ Drug Allergies: _____

INSURANCE INFORMATION: Primary Insurance: Name of Insurance Company: _____ Employer: _____ Subscriber/ Policy Holder: _____ Date of Birth: ____/____/____ Contract/Policy #: _____ Group/Plan # _____

Secondary Insurance: Name of Insurance Company: _____
Employer: _____ Subscriber/ Policy Holder: _____
Date of Birth: ____/____/____ Contract/Policy #: _____
Group/Plan #: _____

Insurance Authorization: I hereby authorize Dr. Baskind 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 myself or dependents. I understand that I am responsible for any amount not covered by insurance.

HIPAA:

I have read the HIPAA office policies. They are posted on the website or in our office _____

Initial

Date: _____ Signature: _____

Witness: _____