Patient Registration – Adult

Steven G. Haupt, Ph.D.

Date: _____

Patient Name: _____ Nickname: _____

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

Address: _____ City: _____Zip Code: _____

Telephone: Cell #: _____ Work # : _____

Patient's Employer: _____ Employer Phone: _____

Primary Care Physician: _____ Phone #: _____

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. Haupt 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 office _____
initial

Date: _____ Signature_____

Witness _____