Richland Psychology - Registration Form

Client Name: _____ Today's Date: _____

Street Address: _____ Date of Birth: _____

City, State, Zip: _____ Email: _____

Primary Phone: _____ Alternate Phone: _____

Soc Sec #: _____ Gender: _____

Primary Care Physician: _____

May we contact your primary care physician to coordinate care? Yes or No (circle one)

Do you prefer text or voice (circle one) reminders to what phone number? _____

Primary Insurance Information:

Insurance Company: _____ Employer: _____

Name of Employee / Insured: _____ Relationship to Client: _____

Birthdate of Employee / Insured: _____

Contract #: _____ Group #: _____

Secondary Insurance Information (if applicable):

Insurance Company: _____ Employer: _____

Name of Employee / Insured: _____ Relationship to Client: _____

Birthdate of Employee / Insured: _____

Contract #: _____ Group #: _____

I authorize payment of benefits directly to the provider and the release of clinical information needed to submit a claim to the insurance company. I am responsible for any co-payments and deductibles according to the terms of my insurance plan. I understand that co-payments are due at the time of service. I have been provided HIPAA privacy information and I understand my privacy rights.

Signature of Responsible Party: _____