

Registration Information

Date: _____

Please use this page only for information about the patient (regardless of age)

First Name _____ Middle Initial ____ Last Name _____

Preferred Name _____ (nickname)

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

County _____

Patient lives alone with _____

Patient lives in a private home apartment dormitory sorority/fraternity house

other _____

Sex Male Female Date of Birth _____

Social Security Number _____

Email Address (if you would like for us to have it) _____

Telephone Home _____ Messages OK? Yes No

Cellular _____ Messages OK? Yes No

Office _____ Messages OK? Yes No

Pager _____

Best number for messages reminding you of appointments _____

Who should we contact if an emergency occurs? _____

and what is the phone number? _____

Marital Status Single Married Other _____

Employment Status Full-time Part-time Self-employed On Active Military Duty

Disabled Leave of Absence Not Employed

Retired Student

Occupation _____ Religion _____ (if you wish to specify)

Education Highest grade or degree completed _____

INSURANCE INFORMATION

Date: _____

Patient name: _____

Insurance Information (If you have more than one insurance, please ask for additional forms)

Insurance Type Primary (first payer) Secondary (second payer) Tertiary (third payer)

Insurance Information Subscriber is Patient Patient's Spouse Patient's Child

Subscriber Information

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____ (nickname)

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Telephone _____ Work Telephone _____

Social Security Number _____

Sex Male Female Date of Birth _____

Insurance Company Information

Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Telephone _____

Eligibility Information

Insurance ID No. _____ Policy Group No. _____

Plan Name _____ Effective Date of Coverage _____

If Property or Casualty insurance coverage, please give claim number _____

Subscriber Employment

Employment Status Full-time Part time Self-employed

On Active Military Duty Disabled Leave of Absence

Not Employed Retired

Employee ID _____ Retirement Date _____

Employer Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Employer ID _____

Financial Responsibility

Copayment Fixed Amount _____ Yearly Deductible _____

Percentage _____

Responsible Party Information

Date: _____

Patient Name _____

Responsible Party other than patient or insurance. (Parent, other relative, guardian, etc.)

Person other than the patient or insurance who will be responsible for payment. (Ask for more sheets if needed)

_____ If no one other than the patient and his/her insurance is responsible for payment on this account, check here and leave the rest of this form blank.

Responsibility Order Primary (first payer) Secondary (second payer) Tertiary (third payer)

First Name _____ Middle Initial _____ Last Name _____

Preferred Name _____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Sex Male Female Date of Birth _____

Responsible Party's Social Security Number _____

Responsible party is the parent or guardian for dependent patient.

If not, please specify how the responsible party is related to the patient _____

Telephone Home _____ Cellular _____

Office _____ Pager _____

Message _____

I, _____, agree to be responsible for this patient's bill for psychological services from Davis & Davis, Clinical Psychologists, PC. I understand that if for any reason insurance does not reimburse these services in full, I will be responsible for whatever portion of the bill remains (If Davis & Davis has a contractual agreement with your insurance company to accept less than our usual fees, we will honor that agreement). I understand that co-payments are expected at the time of service and will make arrangements to have those co-payments paid at each appointment or prior to the appointment. I further understand that significant payment toward any outstanding balance is expected each month if services are to be continued. I understand that to cancel this agreement, I must notify Davis & Davis in writing expressing clearly the identity of the account and that I can no longer assume financial responsibility for further services. Such a cancellation becomes effective when received at our office and does not in any way relieve responsibility for payment for services provided prior to that date. Finally, I understand that if I cease making monthly payments prior to the entire balance on this account being paid, formal collection mechanisms may be used necessitating the release of my name and other contact information on this form.

I am aware that assuming financial responsibility for this patient's services does not in any way entitle me to have access to the clinical records concerning this patient. Access to clinical records is governed by confidentiality laws, rules, and regulations and is a separate issue from financial responsibility.

Signature

Date

Witness

Davis & Davis, Clinical Psychologists, PC
701 University Boulevard East, Suite 204
Tuscaloosa, AL 35401
Phone (205) 758-7343

NOTICE OF PRIVACY PRACTICES – PATIENT ACKNOWLEDGEMENT

I HAVE BEEN MADE AWARE OF THE PRIVACY PRACTICES FOR THIS OFFICE AND UNDERSTAND THAT I MAY RECEIVE A COPY OF THE HIPAA GUIDELINES UPON REQUEST.

Effective Date: April 14, 2003
Amended Date: March 15, 2005

Patient Name (Printed) _____

Patient Date of Birth: _____

Patient Signature _____

FOR PATIENT'S WITH A LEGAL REPRESENTATIVE

Name of Representative (Printed) _____

Representative's Signature

Date

Witness Signature

Date

Davis & Davis, Clinical Psychologists, PC
701 University Boulevard East, Suite 204
Tuscaloosa, AL 35401
Phone (205) 758-7343

Consent for Communications from this Office

I hereby authorize this Practice to:

_____ Contact me by telephone to remind me of scheduled appointments. I request that I be notified at one of these telephone numbers:

1st option _____

2nd option _____

_____ Leave messages of appointment reminders on my answering machine or with the following individual:

I understand that I can revoke this consent in writing at any time, except to the extent that the practice has already taken action in reliance upon it.

Printed Name

Patient or Legal Representative's Signature

Date

Printed Name of Legal Representative

Relationship to Patient

Witness's Signature

Date

Davis & Davis, Clinical Psychologists, PC

Doreen Davis, Ph.D.
Paul W. Davis, Ph.D.

701 University Boulevard East, Suite 204
Tuscaloosa, AL 35401
Phone (205) 758-7343

www.southernpsychologists.com

PATIENT CONTRACT

CHARGES ARE DUE AT THE TIME OF SERVICE.

Insurance companies require collection of deductibles and co-pays at the time of service. If you need to make other arrangements, please do so in advance of your appointment. Please do not hesitate to discuss fee and payment issues with us at any time.

APPOINTMENTS ARE TIME THAT YOU CONTRACT WITH THE PROVIDER TO SET ASIDE FOR YOU. If you need to re-schedule or cancel an appointment, please do so by calling our office at least one business day prior to the scheduled time so that the time can be offered to someone else. If you do not provide us with adequate notice of the need to reschedule or cancel an appointment, we reserve the right to bill you for any amount we deem reasonable up to the full amount that would have been charged for the scheduled appointment.

I have read, understand, and agree to the above. I agree to accept the services of Doreen Davis, Ph.D. and to accept the fees for those services as a lawful debt. I promise to pay said fees as outlined above. This includes an agreement to pay costs of collections, attorney fees, and court costs if necessary. I waive now and forever the right to claim exception under the Constitution and laws of the State of Alabama or any other state. I also understand that failure to pay these fees may result in release of my name, known phone numbers and addresses, and other information during the collection process.

_____ (Initial here) I request Doreen Davis, Ph.D and/or Paul W. Davis, Ph.D.. to file my insurance claims and I hereby authorize the release of any psychiatric, psychological, or other medical information needed to process those claims.

AUTHORIZATION TO PAY INSURANCE BENEFITS: If I have not paid my visits in full, then I hereby now and forever authorize and direct all payment(s) to be made directly to Doreen Davis, Ph.D. and/or Paul W. Davis, Ph.D., who rendered service for the benefits payable from all plans of health insurance or benefit programs otherwise payable to me. A copy of this is as valid as the original.

PERMISSION FOR TREATMENT OR SERVICES

Permission is hereby given to Doreen Davis, Ph.D. and/or Paul W. Davis, Ph.D. to render treatment and/or service to

_____ whose relationship to me is: _____ Self
(write in patient's name)
_____ Child _____ Other (Specify: _____).

Patient Signature Date Witness Signature Date

Patient's Representative's Signature Date