

Registration Form

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 FORM

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 Form

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
3610 Watermelon Road Suite 105
Northport, AL 35473
Phone (205) 758-7343
Fax (205) 758-7558

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
3610 Watermelon Road, Suite 105
Northport, AL 35473
Phone (205) 758-7343
Fax (205) 758-7558

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