UNIVERSITY PSYCHIATRIC PRACTICE, Inc.

Patient Registration Form

New Patient - Date of Initial Appointment_______________ **Established Patient**

Patient Information

Name____Birthdate______________Home Phone______________
Last First MI

Address_________________________________

_______________City/State/Zip_________________________________

Social Security Number____________________________________Sex: Female Male

Marital Status: Minor Single Married Divorced Widowed Separated

Patient's Employer_______________________________________City/State/Zip__________________________________

If patient is a student, name of school_________________________________Cty/St/Zip___________________________

Family or Primary Care Physician____Phone Number________________

Person to contact in emergency_______________________Phone Number_________________Relationship______________

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder____Relationship to patient______________
Last First MI

Address____City/State/Zip__________________________________

Social Security Number____________________________________Birthdate__________________________

Insurance Co_________________________________Ins. ID#__________________________Group#____________

Ins. Co. Address_______________________________City/State/Zip_____________________________________

Employer_______________________________________Work Phone__________________________________

Please note if this is a Workers Compensation or No Fault Claim.

CONTINUED ON REVERSE SIDE

INSURANCE INFORMATION

Secondary/Additional Insurance

Policy Holder____________________________________Relationship to patient______________
Last First MI

Address__________________________________City/State/Zip__________________________

Social Security Number____________________________Birthdate____________________

Insurance Co________________________Ins. ID#____________________Group#__________

Ins. Co. Address________________________City/State/Zip______________________________

Employer______________________________Work Phone__________________________

BY SIGNING BELOW I CONSENT TO TREATMENT AND ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE UNIVERSITY PSYCHIATRIC PRACTICE. INC.'S "NOTICE OF PRIVACY PRACTICES"

______________________________ __________________
Signature ***Date***

____
Print Name

PLEASE READ AND SIGN STATEMENT BELOW TO AUTHORIZE PAYMENT OF BENEFITS.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES INDICATED BELOW:__________________________________ ______________
Signature ***Date***

____
Print Name

It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

IN ORDER TO CONTROL COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. YOU MAY ALSO CHARGE YOUR VISIT TO VISA, MASTERCARD, OR AMERICAN EXPRESS.

If this account is assigned to an attorney for collection and/or legal action, you will be responsible for associated attorney fees and collection costs.
I authorize the release of any information to determine liability for payment and to obtain reimbursement on any claim.
I request that any payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to University Psychiatric Practice Plan, Inc.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

rev. 4/7/2003