Denise L. Newman, Ph.D
Clinical and Developmental Psychologist

PATIENT REGISTRATION

Patient Information

Full Name: _____
Referred By:_____
Address:_____
City: _____State ____ Zip _____
Phone: (C)_____ (Other) _____
Date of Birth: _____ Sex: M or F
Marital Status: _____
Social Security #:_____
Driver's License #:_____
Employment: FT PT Student (*Circle One*)
Occupation: _____
Employer Address:_____
E-Mail: _____
Appointment reminders by text/SMS? Yes No

Account Guarantor Information

Name: _____
Address: _____
City:_____ State:____ Zip: _____
Cell Phone: _____
Phone (H):_____ (W) _____
Relationship to Client: _____
Guarantor Social Security #: _____
Date of Birth: _____
Employer/Occupation: _____
Employer Address:_____
Email Address:_____
Emergency Contact: _____
Phone/Address:_____
_____

Payment and Insurance Information

Insurance Company Name: _____
Member ID: _____ Group Number: _____
Office Visit Co-pay Amount: _____ Deductible Amount: _____
Address: _____
Phone: _____
Policy Holder Name: _____
Policy Holder's Date of Birth: _____ Relationship to Patient: _____
Employer: _____

Charge / Credit Card Authorization

Card Holder's Name: _____Relationship to Patient:_____
Card Number: _____ Exp. Date:_____
Authorization Code: _____ Card Type: MC VISA MC-Debit VISA-Debit (*Circle One)*
Billing Address of Card: _____
City: _____ Zip Code: _____ Phone:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agency and its agents to determine benefits for services provided or benefits for related services. **I request that you file insurance claims for the services rendered, and will provide all necessary information for you to do so. YES_____ NO _____**

ASSIGNMENT OF BENEFITS (FOR IN-NETWORK INSURANCE ONLY): I hereby authorize payment of any insurance benefits be made directly to Dr. Newman for services provided to me. **YES_____ NO _____**

FINANCIAL RESPONSIBILITY OF ACCOUNT: I understand that I am ultimately financially responsible to Dr. Newman for all charges for services incurred, including those not covered by my insurance. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. **YES_____ NO _____**

_____ _____
Signature of Patient Date Witness Date
If minor, signature of responsible person