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

PATIENT REGISTRATION

Patient Information

Full Name: _____ Date of Birth: ____/_____/_____
Address: _____ City: _____ State: _____ Zip _____
Phone: **(C)_____ (Other)_____
***Okay to send appointment reminders by text message/SMS? YES _____ NO _____*

Gender: _____ Marital Status: _____ Social Security #: _____
Driver's License #: _____ Referred By: _____
E-mail: _____
Employment: FT PT RET DIS UNEMP Line of Work or Occupation: _____
Employer Address: _____

Account Guarantor Information:

Name: _____ Date of Birth: ____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Relationship to Client: _____

Payment and Insurance Information

Insurance Company Name: _____ Policy Eff Date: ____/_____/_____
Member ID: _____ Group Number: _____
Office Visit Co-pay Amount: _____ Deductible Amount: _____
Address: _____
Phone: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____ Relationship to Patient: _____
Policy Holder 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 AMEX (*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 for insurance claims 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 I 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** _____

GOOD FAITH ESTIMATE (FOR OUT-OF-NETWORK OR SELF-PAY ONLY): If I do not have insurance or I am not using insurance, I have been provided with a "Good Faith Estimate Statement of Expected Charges" detailing estimated costs and ongoing session costs from this health care provider **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** _____

_____ Date _____ Date
Signature of Patient Witness
If minor, signature of guarantor