Greatland Clinical Associates, LLC

Dba Greatland Mental Health, LLC

OFFICE REGISTRATION FORM

PATIENT INFORMATION		
Name:		
Date of birth:	SSN:	
Current address:		
City:	State:	ZIP Code:
Male Female	Phone #	Alt Phone #
Emergency Contact Name:		
Relationship to Patient:	Phone #	
Primary Medical Provider:		
Who referred you to see us?		

INSURANCE INFORMATION		
Primary Insurance:		
Insurance address:		Effective Date:
Phone:		
Policy ID:	Group:	
Policy Holder:	Policy Holder DOB:	Policy Holder SSN:
Relationship to Patient:		
Secondary Insurance:		
Insurance Address:		Effective Date:
Phone:		
Policy ID:	Group:	
Policy Holder:	Policy Holder DOB:	Policy Holder SSN:
Relationship to Patient:		

BILLING NOTIFICATION

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME BY GREATLAND MENTAL HEALTH, LLC DBA GREATLAND CLINICAL ASSOCIATES, LLC (GCA). MY INSURANCE COMPANY WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE INSRUANCE INFORMATION TO GCA. **I AM RESPONSIBLE FOR MY PORTION OF THE BILL AT THE TIME THAT SERVICES ARE RENDERED.** I HEREBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO GCA. I FURTHER AUTHORIZE RELEASE BY GCA OF ANY INFORMATION NECESSARY TO MY INSURANCE COMPNAY FOR PAYMENT OF CLAIMS

SIGNATURE OF PATIENT	DATE
PATIENT NAME (PRINTED PATIENT NAME)	