

GREATLAND CLINICAL ASSOCIATES

OFFICE REGISTRATION FORM

PATIENT NAME: _____ DATE OF BIRTH: _____ MALE FEMALE
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET / P. O. BOX) (CITY) (STATE) (ZIPCODE)

PATIENT'S HOME PHONE #: _____ PATIENT'S WORK PHONE #: _____

EMPLOYER: _____ PATIENT'S SOCIAL SECURITY #: _____

EMPLOYER'S ADDRESS: _____ OK TO LEAVE MESSAGE ON HOME & WORK YES / NO

SPOUSE OR PARTNER: _____ THEIR DAYTIME PHONE #: ()
(LAST) (FIRST) (MIDDLE)

EMERGENCY CONTACT'S NAME: _____ CONTACT'S RELATIONSHIP TO PATIENT: _____
(OTHER THAN SPOUSE) _____ IS THE CONTACT THE PATIENT'S GUARDIAN? _____

EMERGENCY CONTACT'S HOME PHONE #: () CONTACT'S WORK PHONE #: ()

WHO IS YOUR PRIMARY MEDICAL CARE PROVIDER? _____ WHO REFERRED YOU TO SEE US? _____

FORM OF PAYMENT FOR SERVICES

CIRCLE FORM OF PAYMENT: PRIVATE INSURANCE(S) SELF-PAY WORKER'S COMPENSATION MEDICARE ONLY MEDICARE AND PRIVATE SUPPLEMENTAL INSURANCE MEDICAID ONLY MEDICARE & MEDICAID

PRIMARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY I. D. NUMBER: _____ GROUP I. D. NUMBER: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

SECONDARY INSURANCE INFORMATION:

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

POLICY I. D. NUMBER: _____ GROUP I. D. NUMBER: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____ POLICY HOLDER'S DATE OF BIRTH: _____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME BY GREATLAND MENTAL HEALTH, LLC (GMH). MY INSURANCE COMPANY WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE INSURANCE INFORMATION TO GMH. **I AM RESPONSIBLE FOR MY PORTION OF THE BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS WORKER'S COMPENSATION, MEDICARE & SUPPLEMENTAL INSURANCE, OR MEDICARE & MEDICAID COVER MY CLAIM.** I HEREBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO GMH. I FURTHER AUTHORIZE RELEASE BY GMH OF ANY INFORMATION NECESSARY TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS.

PATIENT'S SIGNATURE

DATE