Psychiatric Services of Prescott

REGISTRATION FORM

DATE_____ REFERRED BY WHOM_____

PATIENT NAME_____
Last First Middle

AGE _____ SEX____ DATE OF BIRTH_____

ADDRESS_____
Street City State Zip Code

MAILING ADDRESS_____
Street / PO Box number City State Zip Code

HOME PHONE(___)_____ DRIVERS License No_____

CELL PHONE(___)_____ EMAIL _____

OCCUPATION OF PATIENT_____

EMPLOYER_____

SPOUSE OR PARENT'S NAME OR FINANCIALLY RESPONSIBLE PARTY_____

OCCUPATION_____

EMPLOYER _____WORK PHONE (___)_____

ADDRESS_____
Street City State Zip Code

EMERGENCY INFORMATION:

Emergency Contact: _____

RELATIONSHIP_____ PHONE NUMBER (___)_____

ADDRESS_____
Street City State Zip Code

Psychiatric Services of Prescott

I understand and agree, I am a private patient, personally responsible for payment of service rendered at Psychiatric Services of Prescott. This office ***does not*** file insurance claims. If I am a Medicare beneficiary, I will ***not*** expect claims to be filed or reimbursements to be made by Medicare or my secondary insurance, as Psychiatry Services of Prescott has opted out of Medicare. By signing this I am knowingly receiving services from an opted out provider . If my account should ever be in default, I will be responsible for all legal/collection fees in addition to the balance due.

I understand payment is due at the time of service. Psychiatric Services of Prescott will not bill insurance carriers, but will provide a detail statement to be submitted by the patient upon request. In the event that my insurance carrier requests additional information in order to process my claims, I authorize the release my information.

I certify that the above information is true and correct to the best of my knowledge.

SIGNATURE_____ DATE_____