SHEILA DAY
COUNSELING

Registration Form

Date _____

Patient Name_____
Last First Middle

If patient is a minor, patient lives with_____ Relationship _____

Birthdate_____ Age_____ Sex_____ Social Security #_____

Address_____
Street City State Zip

Home Phone (___)_____Work Phone (___)_____Marital Status_____

Occupation _____Retired ___Full-time Student ___ Part-time Student ___

Spouse Name_____ SS#: _____ DOB_____

Responsible Party: If Other than the Patient, Please Complete (should match the person signing the consent for treatment form):

Name_____ Relationship_____ SS#: _____

Address_____
Street City State Zip

Home Phone (___)_____Work Phone (___)_____DOB_____

Employer Name & Address_____

Emergency Contact: Nearest Friend/Relative Not Living with You

Name_____ Relationship to Patient_____

Address_____ Home/ Work Phone (___)_____

Referring Physician:

Family or Primary Care Physician_____ Phone (___)_____

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Financial Responsibility Statement/ Release of Information Authorization

"I authorize Sheila Day Counseling & Lakeshore Medical Billing, LLC to contact my employer and my insurance company in order to verify insurance benefits. I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Provider for services received. I also authorize the release of information to listed physicians and/ or individuals".

X_____ Date _____
Signature of Patient or Legal Guardian

"I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my provider and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees."

X_____ Date _____
Signature of Patient or Legal Guardian