

Registration Form

Today's Date _____

Please complete all areas on both pages. If you have any questions, please ask our receptionist for assistance.

Client Name: _____ Birth Date: _____ Sex: [] M [] F

SS# _____ Marital Status: [] Single [] Married [] Divorced [] Widowed

Address: _____ City _____ State: _____ Zip _____

Telephone Numbers - Home (_____) _____ Cell (_____) _____

Work (_____) _____ Okay to call and or leave messages at [] Home [] Work [] Cell

Spouse: _____ Referred By: _____

Nearest relative not living in same household: Name _____ Relation _____

Address: _____ Telephone (_____) _____

Parent or Guardian Information (Responsible Party)

Parent/Guardian/Guarantor: _____ Birth Date: _____ Sex: [] M [] F

SS# _____ Relationship to Patient _____

Mailing

Address: _____ City _____ State: _____ Zip _____

Telephone Numbers - Home (_____) _____ Cell (_____) _____

Work (_____) _____ Occupation: _____

Primary INSURANCE INFORMATION

Name of Insurance: _____ Employer: _____

Policy #: _____ Group #: _____ Effective Date: _____

Insured's Name: _____ Birth Date: _____ Sex: [] M [] F

SS# of Insured: _____ Relationship to Patient: _____

Mailing

Address: _____ City _____ State: _____ Zip _____

Street

Address (if different): _____ City _____ State: _____ Zip _____

Secondary INSURANCE INFORMATION

Name of Insurance: _____ Employer: _____

Policy #: _____ Group #: _____ Effective Date: _____

Insured's Name: _____ Birth Date: _____ Sex: [] M [] F

SS# of Insured: _____ Relationship to Patient: _____

Mailing

Address: _____ City _____ State: _____ Zip _____

Street

Address (if different): _____ City _____ State: _____ Zip _____

Primary Insurance _____ Telephone _____

Max. Visits _____ Co-Pay/Percentage _____ Deductible _____ Authorization YES or NO

Coverage: _____ LPC _____ LCSW _____ APRN _____ Testing _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

Secondary Insurance _____ Telephone _____

Max. Visits _____ Co-Pay/Percentage _____ Deductible _____ Authorization YES or NO

Coverage: _____ LPC _____ LCSW _____ APRN _____ Testing _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

Code _____ Sessions (#) _____ Authorization _____ Dates: _____ to _____

For Office Use Only

Please read carefully the following and initial

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/Client/Guardian is still responsible for co-pays, unpaid balances, or charges that are not covered by the insurance carrier.

FINANCIAL AGREEMENT

I hereby assume full responsibility for all charges incurred for professional services rendered by Madison Behavioral Diagnostic and Treatment Services, unless the services are deemed "paid in full" as a result of a contractual agreement between Madison Behavioral Diagnostic and Treatment Services and my insurer. Behavioral Diagnostic and Treatment Services uses Holloway Credit Services for outstanding bills of 6 months or greater. **Initial here:** _____

GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to Madison Behavioral Diagnostic and Treatment Services the medical/psychiatric benefits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible for charges not covered by this agreement. **Initial here:** _____

MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. **Initial here:** _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Madison Behavioral Diagnostic and Treatment Services to release any medical, psychiatric, infectious disease or drug and/or alcohol related information to my referring physician, other healthcare providers within Madison Behavioral Diagnostic & Treatment Services and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client I further authorize the release of information to insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date. **Initial here:** _____

Cancellation and Missed Appointment Policy:

Scheduled appointment times are reserved especially for you. **If an appointment is missed or cancelled with less than 24 hours notice, you may be billed for half the missed or cancelled appointment.** Your insurance company cannot be billed for fees associated with missed or cancelled appointments. We provide appointment cards for your convenience, but are not responsible for reaching you to remind you of your scheduled appointment. If you come in on a cancellation call basis, your original appointment is not cancelled unless you expressly request such. **Initial here:** _____

Consent for Treatment:

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. **Initial here:** _____

Emergency Access:

Your practitioner or a covering practitioner is available after hours to handle emergencies. By calling the office number after hours, you will be instructed as to how to contact the on-call practitioner. You may be charged for telephone consultations in excess of 5 minutes. Your insurance company may not cover extended phone calls. **Initial here:** _____

Receipt of Privacy Practices

My Initials below indicates that I have had an opportunity to review a copy of the Privacy Practices of Madison Behavioral Diagnostic and Treatment Services and, that I have been offered a paper copy for my further review outside the clinic upon my request. I am also aware that I can request a further copy or clarification of the Privacy Practices at any time in the future.

(Initial one): _____ **Copy Received** _____ **Copy Declined**

Patient or parent/guardian of minor

Date: _____