INNERVISIONS COUNSELING & CONSULTING CENTER, LLC

840 STATE ROAD 136, SUITE #1 IN BARABOO, WI 53913

231 E. STATE STREET IN MAUSTON, WI 53948 * 129 E. BRIDGE STREET IN NEW LISBON, WI 53950

Date _____ Therapist Name_____

Diagnosis _____ Physician Name_____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

_____

Patient Name: First Middle Last

_____

Street Address

_____

City, State, Zip Code

_____ _____/____

Phone number D.O.B. Age

_____ M F

Cell phone number Sex

_____

Social Security Number

_____

Emergency Contact Name and Phone Number

_____

Patient email (would you like to receive email statements?) Y N

_____

Patient Employer - Address - Phone

S M D W _____

Marital Status Name of Spouse

BILLING INFORMATION

_____

Responsible Party For Bill (If same as patient, omit)

_____

Street Address (If same as patient, omit)

_____

City, State, Zip Code (If same as patient, omit)

_____

Responsible Party Email Address

_____

Responsible Party's Employer (If same as patient, omit)

_____

Responsible Party's Employer Address and Phone

_____

Nearest Friend or Relative (not at same address) Relationship

_____

Address and Phone Number of above

PRIMARY INSURANCE

_____

Policyholder Name Date of Birth

_____

Insurance Company Name

_____

Insurance Street Address

_____

City, State, Zip Code

_____

Insurance ID# Group #

Medicare #_____

SECONDARY INSURANCE

_____

Policyholder Name Date of Birth

_____

Insurance Company Name

_____

Insurance Street Address

_____

City, State, Zip Code

_____

Insurance ID# Group #

Medical Assistance #_____

Authorization/Assignment of benefits: Please sign by the "X" for release of your records to your insurance for medical information necessary to process insurance and for payment to INNERVISIONS by your insurance. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original copy. I understand that partial payments made by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I also agree to pay INNERVISIONS any payments I receive from my insurance company for claims filed by INNERVISIONS. I agree to the fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee, INNERVISIONS, to release all information to secure payment on my behalf.

X_____ DATE _____