Innervisions Counseling & Consulting Center S.C.

840 State Road 136, Suite #1, Baraboo WI 53913

231 East State Street, Mauston WI 53948

Phone: 608.477.9858 Fax: 877.560.0578

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Therapist Name: |  |
| Diagnosis: |  | Physician Name: |  |

PATIENT REGISTRATION FORM

*\*input fields will expand as you type*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION: | | | | | | |
| Full Name (F/M/L): |  | | DOB: | |  | |
| Street Address: |  | | SSN: | |  | |
| City/State/Zip: |  | | Age: | |  | |
| Spouse Name (F/M/L): |  | | Sex: | |  | |
| Email: |  | | Employer: | |  | |
| Emergency Contact: |  | | Employer Address: | |  | |
| Emer Contact PH #: |  | | Employer Phone: | |  | |
| Marital Status: |  | |  | |  | |
| Home PH: |  | |  | |  | |
| Cell PH: |  | |  | |  | |
| ADDITIONAL INFORMATION: | | | | | | |
| ***BILLING INFORMATION: Responsible Party:*** | | | | | | |
| Full Name: | |  | | | | Same as patient |
| Street Address: | |  | | | | Same as patient |
| City/State/Zip: | |  | | | | Same as patient |
| Email: | |  | | | | Same as patient |
| Employer: | |  | | | | Same as patient |
| Employer Address: | |  | | | | Same as patient |
| Employer Phone #: | |  | | | | Same as patient |
| ***Nearest Friend or Relative:*** | | | | | | |
| Name: | |  | | | | |
| Street Address: | |  | | | | |
| City/State/Zip: | |  | | | | |
| Phone: | |  | | | | |
| Relationship: | |  | | | | |
| INSURANCE: | | PRIMARY INSURANCE: | | SECONDARY INSURANCE: | | |
| Policyholder Name: | |  | |  | | |
| Policyholder SSN: | |  | |  | | |
| Date of Birth: | |  | |  | | |
| Insurance Company Name: | |  | |  | | |
| Street Address: | |  | |  | | |
| City/State/Zip: | |  | |  | | |
| Insurance ID#: | |  | |  | | |
| Insurance Group #: | |  | |  | | |
|  | | Medicare # | | Medical Assistance # | | |
| Identifying #: | |  | |  | | |

***Authorization/Assignment of Benefits:*** *Please sign/type 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. (A typed signature on this document will be treated in all respects as having the same force and effect as original signatures.) 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: |  |

*A typed signature on this document will be treated in all respects as having the same intended obligation(s) and effect as original signatures.*