

**PATIENT REGISTRATION**

**PLEASE PRINT AND COMPLETE ALL ENTRIES**

<b>PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)</b>		<b>ADDRESS</b>			
<b>CITY, STATE</b>		<b>ZIP</b>	<b>HOME PHONE</b>		<b>CELL PHONE</b>
<b>PATIENT DATE OF BIRTH</b>	<b>PATIENT SSN</b>	<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>MARITAL STATUS</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
<b>PATIENT EMPLOYER NAME</b>		<b>PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)</b>			<b>EMPLOYER PHONE</b>
<b>INSURED/RESPONSIBLE PARTY INFORMATION</b>		<b>RELATION TO PATIENT:</b> <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian			
<b>NAME (FIRST -- LAST -- MIDDLE INITIAL)</b>		<b>ADDRESS (if different from patient)</b>			
<b>HOME PHONE</b>	<b>WORK PHONE</b>	<b>SSN</b>	<b>BIRTH DATE</b>	<b>EMPLOYER</b>	
<b>INSURANCE INFORMATION</b>					
<b>PRIMARY INSURANCE NAME</b>		<b>ADDRESS (STREET - CITY - STATE - ZIP)</b>			<b>PHONE</b>
<b>GROUP NUMBER</b>	<b>ID NUMBER</b>	<b>EMPLOYER</b>		<b>EMPLOYER PHONE</b>	
<b>SECONDARY INSURANCE NAME</b>		<b>ADDRESS (STREET - CITY - STATE - ZIP)</b>			<b>PHONE</b>
<b>GROUP NUMBER</b>	<b>ID NUMBER</b>	<b>EMPLOYER</b>		<b>EMPLOYER PHONE</b>	
<b>REFERRING PHYSICIAN (if applicable)</b>			<b>REFERRING PHYSICIAN'S PHONE NUMBER</b>		
<b>IN CASE OF EMERGENCY CONTACT</b>			<b>RELATIONSHIP</b>	<b>PHONE NUMBER</b>	

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees. I also agree to pay a \$50.00 cancellation fee if I do not give a least 24 hours advance notice if unable to keep an appointment.

<b>SIGNATURE (Patient or, if minor Signature of parent or guardian)</b>	<b>DATE</b>
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<b>Authorization to release health information to:</b>			
<b>NAME(S)</b>		<b>ADDRESS</b>	
<b>CITY, STATE</b>		<b>ZIP</b>	<b>HOME PHONE</b>
			<b>DAYTIME PHONE</b>
<b>DATES OF SERVICE</b>		<b>AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)</b>	
<b>FROM:</b>	<b>TO:</b>	<input type="checkbox"/> NEVER <b>DATE:</b>	
Release the following information:			
<input type="checkbox"/> All Records	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Psychological Reports	<input type="checkbox"/> Billing History <input type="checkbox"/> Patient History

<b>RELEASE OF INFORMATION</b>		
I understand that:		
<ul style="list-style-type: none"> <li>Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.</li> <li>I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).</li> <li>My records are protected and cannot be disclosed without written permission</li> <li>This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.</li> </ul>		
<b>SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE</b>	<b>DATE</b>	<b>EMAIL</b>
<b>IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT</b>		<b>SIGNATURE OF WITNESS (Optional):</b>

# HealthPoint Associates

## How were you referred to our office?

- Physician     Co-Worker     Family     Hospital     Phonebook     Internet     Friend  
 Other \_\_\_\_\_

## Presenting Symptoms: What physical or emotional symptoms brought you here today?

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## Current Stressors: Are there significant changes in your life which may have contributed to the symptoms which brought you here? \_\_\_\_\_

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## Previous Counseling/Medication Management History: \_\_\_\_\_

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