Intake Date _____ Presenting Diagnosis _____

Patient Registration Form

Patient

Name: _____ Date of Birth _____

Address: _____ Relationship to Insured: Self Spouse Child Other

_____ Sex F ___ M _____

_____ Marital Status _____

Phone (h) _____ Student or Work Status: F/T P/T

Phone (w) _____ Employer _____

Phone (cell) _____ Referred By _____

Primary Care Physician Name _____ Phone _____

___ I give Kyoung-Hi Dickson, LMFT permission to contact my PCP to coordinate care.

Insured / Guarantor Information

Insured Name _____ Date of Birth _____

Address _____ Sex F ____ M_____

_____ Employment Status F/T P/T Unempl Ret

Phone (h) _____ Phone (cell) _____

Employer _____ Occupation _____

Insurance Company Name _____ ID no. _____

Plan Type _____ Insurance Phone no. _____

** Please provide secondary insurance information for this patient on the back.

Beneficiary / Guarantor Signature (Initial & Sign)

____ I request that payment of authorized insurance benefits be made on my behalf or my child's behalf to Kyoung-Hi Dickson, LMFT for any medical services provided to me by her.

____ I authorize Kyoung-Hi Dickson to release to my insurance company any medical or other information necessary to determine the benefits payable for treatment-related services.

____ I understand that even though Kyoung-Hi Dickson will submit claims to my insurance, I am responsible for the co-payment, co-insurance, deductible or other charges not covered by insurance.

____ By signing this document, I also acknowledge that I have received a copy of the practice's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my (or my child's) privacy rights.

Signature of Insured or Parent/Guardian _____ Date _____