EQUALITY MENTAL HEALTH, LLC

PATIENT REGISTRATION AND INSURANCE FORM

NAME: ____ SOC. SEC. NO: ________________________

ADDRESS: _______________________________________ CITY: _________________________________

STATE: ________ ZIP: _____________ PHONE: ____________________ CELL: ___________________

I IDENTIFY MY GENDER AS _______________________________ AGE ____ DATE OF BIRTH: ________

MY PRONOUNS ARE: ____________________________________

SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ CHILD ___

PATIENT EMPLOYER (OR RETIRED): ____

OCCUPATION: ______________________________ BUS. TEL: _________________________________

EMERGENCY CONTACT: _________________________ PHONE: _________________________________

PRIMARY INSURANCE

INSURANCE COMPANY: ____

I.D.# _______________________ GROUP# ____________________ PHONE: ________________________

CLAIMS ADDRESS: ____

____

PERSON RESPONSIBLE FOR ACCOUNT: ____

RELATION TO PATIENT: ______________ DATE OF BIRTH: _____________ PHONE:___________________

ADDRESS (if different from patient): ____

EMPLOYER ADDRESS: ____

WORK PHONE: __________________________ EXTENSION: ________________________

ADDITIONAL INSURANCE: ____

CLAIMS ADDRESS: ____ PHONE: ____________________

SUBSCRIBER NAME: _____________________________ RELATIONSHIP TO PATIENT: _________________

DATE OF BIRTH: _____________________________ INSURANCE ID#: ___________________________

I, the undersigned certify that I have insurance coverage and assign directly to HOWARD C. CUTLER all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize EQUALITY MENTAL HEALTH, LLC to release all information necessary to secure the payments or benefits. I authorize the use of my signature on all insurance submissions. If my account is placed in collection, I understand that I am responsible for all collection agency fees, attorney fees, and all fees pertaining to this collection. Past due bills are subject to interest charges at the rate of 1.5% per month.

SIGNATURE: ____ DATE: ______________________________