CHILD AND FAMILY THERAPY ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	MI:	Sex: M F	Marital status: Sin Mar Div Sep Wid	
Street address:			Age:	Birth date:	
City:	State:	ZIP Code:	Employer	Occupation	
Mobile Phone	Leave Msg. Yes No	Leave Msg. with Whoever Answers Yes No	May we contact you at work? Yes☐ No☐		
Home Phone	Yes No	Yes No	Employment FT☐ PT☐ Student☐ None☐		
Work Phone	Yes No	Yes No	E-Mail		
PCP			Referred by		

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT)

Name	Phone
Address	Relationship
	DOB

EMERGENCY CONTACT

Name	Relationship	
Mobile Phone	Home Phone	Work phone

INSURANCE INFORMATION

Primary

Policy Holder Name	DOB	Relation to Policy Holder	Employer
Insurance Company	Policy Number	Address	
Customer Service Number	Group Number	City/State/Zip	

Secondary

Policy Holder Name	DOB	Relation to Policy Holder	Employer
Insurance Company	Policy Number	Address	
Customer Service Number	Group Number	City/State/Zip	

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CAFTA or insurance company to release any information required to process my claims. I agree to notify CAFTA as soon as I am aware of any changes in my health plan coverage. I clearly understand that final responsibility for payment to CAFTA for any and all services rendered due at the time of the visit belongs to me, I also understand that if I suspend or terminate my care and treatment for any reason, any outstanding balance will be immediately due and payable. I fully understand that a 24 hour notice of a cancellation is recommended. If I fail to attend a scheduled appointment, a no-show fee will be charged equal to half of the full session fee.

Patient/Guardian signature	Date

*Deductible, coinsurance, copayments, and no-show fees require a credit card on file

Visa☐ MasterCard☐ American Express☐ Discover☐	Card Number		
Cardholder Name	Exp. Date	CVV Code	Billing Zipcode

The above information is true to the best of my knowledge. I hereby give consent to charge my credit card above for any outstanding balance at the beginning of each month such as deductible, coinsurance, copayments, no-show fees or other amounts my insurance carrier deems payable by me. I fully understand that payment of deductible, coinsurance, copayments, and no-show fees may be paid prior to the end of the month in order to avoid charge to my credit card.

	Patient/Guardian signature		*Date*	