

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 <input type="checkbox"/> No <input type="checkbox"/> | | |
| Home Phone | Yes No | Yes No | Employment FT <input type="checkbox"/> PT <input type="checkbox"/> Student <input type="checkbox"/> None <input type="checkbox"/> | | |
| 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 <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover <input type="checkbox"/> | 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 |
|----------------------------|------|