2015 PATIENT REGISTRATION FORM

TH: _____

INFORMATION PROVIDED HERE WILL REPLACE ANY INFORMATION PROVIDED BY PHONE. ANSWERS NOT PROVIDED WILL BE DELETED FROM YOUR RECORD. PLEASE ANSWER IN FULL.

First Name: ______________________ Middle Initial: ______Last Name: ______________________________________

New Patient Updated form Check here if no new changes since form was submitted last year.

Date of Birth: ___________ Age:_____ Social Security # _____________________ Gender: M F

Marital Status: Single Married Divorced Widowed Other:______________

Home Address: ____ City: _______________ State: ______ Zip_________

Home Phone: _________________________________ Cell Phone: ____

Work Phone: _________________________________ Additional Phone: _____________________________________

Email Address: ____

(Necessary for announcements, emergency office closings, and communications)

If patient is a minor please provide the name/contact information of person(s) responsible for patient:

Name ____ Phone: ________________________________

Name ____ Phone: ________________________________

How would you like appointment reminders to be sent to you? None (no reminder will sent)

Email using address above Text Message to Carrier Name: _______________ at cell# __________________

Employment Status: Employed Student Other ______________________

Employer Name: ____

Briefly, please describe the reason for this appointment:

____

Whom may we thank for referring you or how did you hear about our office?

____

2015 INSURANCE INFORMATION

TH: ______

PLEASE COMPLETE INSURANCE INFORMATION TO PROVIDE WRITTEN RECORD. IF WE ARE UNABLE TO TAKE YOUR PLAN UPON REGISTRATION THE INFORMATION WILL BE HELD IN THE EVENT WE CAN ACCEPT IT IN THE FUTURE. PLEASE FILL OUT ALL INFORMATION.

Check here if no changes to insurance from the form submitted last year.

Primary Insurance Company: _______________ Name of Policy Holder (if not yourself): __________________________

I.D. # (found on insurance card): _____________________ Policy Holder's Date of Birth _____________________

Secondary Insurance Company: _______________ Name of Policy Holder (if not yourself): __________________________

I.D. # (found on insurance card): _____________________ Policy Holder's Date of Birth _____________________

If patient is a minor, please provide the following insurance information for parent/guardian:

Parent/Guardian name: ____________________________________ Date of Birth: _______________________

Primary Insurance Company: _______________ Name of Policy Holder (if not yourself): __________________________

I.D. # (found on insurance card): _____________________ Policy Holder's Date of Birth _____________________

INSURANCE BILLING AND PAYMENT POLICY

Family & Personal Counseling submits an insurance claim as a courtesy to you. You are responsible for paying your deductible, copay or co-insurance (whichever may apply). If your insurance carrier pays you directly, you agree to prepay us in full at the time of your session. In the event that you receive a check for which you have not already prepaid, you agree to make immediate payment to us. You are asked below to authorize your insurance company to assign all benefits and agree to inform us if there is any change in your insurance carrier. **You understand and agree that regardless of your insurance status, you are responsible for payment in full of services rendered at all times.**

Your signature below indicates your agree and acknowledge our insurance policy and guidelines.

Signature ____ Date: _____________

(Parent/Guardian signature if patient is a minor under 18)

Print Name: ____

ASSIGNMENT OF BENEFITS

I, (Name of policy holder) _______________________________________ hereby assign health benefits to which I am entitled for these services from any public/private insurance and/or any other health plans to: *Ronald Villano Mental Health Counselor, PLLC dba Family & Personal Counseling: 1650 Sycamore Ave. #39; Bohemia, NY 11716.* This assignment will remain in effect until revoked by me in writing. I hereby authorize Family & Personal Counseling to release all information necessary to secure proper payment of benefits.

Your signature below indicates that you agree and acknowledge your assignment of benefits:

Signature ____ Date: _____________

(Parent/Guardian signature if patient is a minor under 18)

Print Name: ____

2015 POLICIES AND GUIDELINES

TH: _____

ANNUAL SIGNATURE IS REQUIRED ON THIS PAGE IN ORDER TO PROVIDE TREATMENT.

CANCELLATION POLICY

We require 48-hour notice for cancellation. While we do understand that there are circumstances at times that are unavoidable and we will take this into consideration, in the event that you cancel or no-show for a scheduled appointment, your credit card may be charged a cancellation fee up to a maximum of $250 per person, per session. **In most standard cases, this fee is $75 for an individual session and $125 for 2 or more.**

METHOD OF PAYMENT

You may pay by cash, check or credit card. Copays, co-insurance, deductibles and other agreed upon session fees are payable at the start of each visit or your appointment may be rescheduled and is subject to a cancellation fee. You agree to keep a valid credit card on file in our office. You agree and acknowledge that you ultimately remain responsible for payment on your account regardless of your insurance benefit status.

SCOPE OF PRACTICE

Family & Personal Counseling reserves the right to refer outside the practice and/or terminate your treatment in the event that it is determined that your needs exceed our scope of practice or when legal remedies are mandated or required.

CONFIDENTIALITY

Your treatment here is kept in the strictest of confidence where applicable by law. Under normal circumstances no one will be permitted any access to any information unless you specifically request, in writing, a release of information. You acknowledge that release of your personal health information may be disclosed to others who have direct or indirect treatment with you and to those necessary to secure payment. At the discretion of the therapist or other agent of this practice, confidentiality may be broken in the event of extraordinary, extreme or life-threatening circumstances. Under HIPPA law, we have the right to refuse to treat you if you choose to refuse disclosure of your personal health information. At all times, we will provide only the minimum necessary information in order to provide the appropriate level of care. Review of HIPPA guidelines is available upon request.

GENERAL CONSENT

This policy summary reflects an active interest in your concerns and you acknowledge that your participation is voluntary. Your signature indicates that you understand, acknowledge and agree to these policies and guidelines.

Your signature below indicates that you agree and acknowledge our policies and guidelines:

Signature ____ Date: ______________

(Parent/Guardian signature if patient is a minor under 18)

Print Name: ____

MAIN OFFICE: 1650 Sycamore Avenue Suite #39 | Bohemia, NY 11716 | 631-758-8290