BAINBRIDGE MENTAL HEALTH, PLLC **Britt Gonsoulin, MD, MPH**

NEW PATIENT REGISTRATION

GENERAL INFORMATION:

Name: ________________________________ DOB: ____________ Sex: ________

Mailing Address: ____

City, State, Zip: ____

SSN: ______________ Employer: ______________________________________

Home Phone: _____________________ Work Phone: _________________________

Cellular Phone: ___________________

Best message phone (check one)? Home _ Cellular _

Work Email: ____

Home Email: ____

MEDICAL AND REFERRAL INFORMATION:

Name of Primary Care Provider: ____

Telephone Number: ______________________ Fax Number: ___________________

Name of Pharmacy: ____

Pharmacy Telephone: _______________ Pharmacy Fax Number: _________________

Who referred you to our practice? _______________________________________

Acknowledgment of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notice of Office Policies and Procedures

I have received a copy of the Notice of Privacy Practices and Policies, and have received a copy of the Notice of Office Policies and Procedures, from Bainbridge Mental Health, PLLC/Britt Gonsoulin, MD, MPH. I understand the cancellation policy.

Patient Signature: ____

Date: ____

If signed by patient's representative, explain relationship. All children age 16 and up sign for themselves

HEALTH INSURANCE INFORMATION

Although we are an out-of-network provider for your insurance carrier, it is important for us to have your insurance information. This allows us to coordinate with you and your insurance carrier to facilitate reimbursement should you wish to submit claims for reimbursement.

PRIMARY HEALTH INSURANCE

Primary Insurance Company: ____

Patient's Relationship to Subscriber(check one): ____Self ____Spouse____Child ____Other

Patient ID: ______________________________ Patient Birth Date: _________________

Subscriber on Policy: ___________________________________

Subscriber ID: ________________________________Subscriber Birth Date: ____________
Subscriber Insurance Group #: ___________________ Subscriber SSN: __________________
Subscriber Address: ___________________________________
*THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: ____
Patient's Relationship to Subscriber(check one): ____Self ____Spouse____Child ____Other
Patient ID: ______________________________ Patient Birth Date: _________________
Subscriber on Policy: ___________________________________
Subscriber ID: ________________________________Subscriber Birth Date: ____________
Subscriber Insurance Group #: ___________________ Subscriber SSN: __________________
Subscriber Address: ___________________________________
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ASSIGNMENT OF BENEFITS: I hereby assign to Bainbridge Mental Health, PLLC/Britt Gonsoulin, MD, MPH my right to the insurance benefits that may be payable to me for the services provided, in my name or in my behalf. I further authorize those payments be made directly to Bainbridge Mental Health, PLLC/Britt Gonsoulin, MD, MPH. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services. The doctor may release all or part of my medical record to the insurance company required for processing any claims. The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.

Patient Signature (for minors over age 13, both parent and child sign):

Signature: ____Date _____________________
If signed by patient's representative, specify relationship