Patient Registration Form

Patient Information

First Name:______________________ Middle Name:__________________ Last Name:____________________

SSN:__________________ DOB:__________________ Gender:__________ AKA:______________________

Mailing Address:__________________________________ City/State/Zip:______________________________

Phone (H) #______________________ Phone (W) #__________________ Cell #________________________

Preferred Phone for Messages:_________________________ Email:________________________________

Race:_____________ Ethnicity:_________________ Language:________________ Marital Status:__________

Employment:_______________________________ Driver's License:___________________________________

Primary Doctor:_____________________________ Phone #____

Referring Doctor:____________________________ Phone #____

Pharmacy:______________________________ City:____________________ Phone #___________________

Responsible Party (Bill To)

First Name:_________________________________ Last Name:______________________________________

DOB:__________________ SSN:____________________ Gender:______________

Mailing Address:____________________________________ City/State/Zip:__________________________

Phone (H) #______________________ Phone (W) #__________________ Cell #________________________

Employment:____

Relationship to Patient:____

Emergency Contact

First Name:______________________________ Last Name:____

Phone (H) #______________________ Phone (W) #__________________ Cell #________________________

Relationship to Patient:____

Patient Name:

Primary Insurance **None:**

Insurance Name:________________________ ID:________________________

Group No:________________________ Group Name/Employer:________________________

Insured Name:____

Insured Address:________________________ City/State/Zip:________________________

Insured Relationship to Patient:________________ DOB:____________ SSN:____________

Secondary Insurance

Insurance Name:________________________ ID:________________________

Group No:________________________ Group Name/Employer:________________________

Insured Name:____

Insured Address:________________________ City/State/Zip:________________________

Insured Relationship to Patient:________________ DOB:____________ SSN:____________

Statesboro Psychiatric Associates (SPA) does not participate with Medicare (or its commercial products), Tricare or Medicaid. I understand that if covered by any of these entities that I must sign a waiver in order to receive treatment at SPA. I understand that the waiver states that I may not file claims with Medicare, Tricare or Medicaid for services rendered by SPA, and that I am fully responsible for payment of these services. I also understand that neither I nor SPA will file with insurance that is secondary to Medicare, and that by signing the waiver I am fully responsible for office visits.

I understand that it is my responsibility to alert Statesboro Psychiatric Associates to any and all changes in my insurance coverage, and that failure to provide these updates in a timely fashion may result in denial of claims by my new insurance company, and that I will be fully responsible for payment of these services.

I understand that unpaid balances are cause for dismissal from the practice, and that in the event that my account is forwarded to an outside agency for collection, a charge of 33% will be added to the outstanding balance to cover this cost.

Signature of Patient/Responsible Party:________________________________ **Date:**____________

*Digital Signature

Credit Card Authorization Form

Name of Patient: ________________________________ Date: ____________________

Full name on Credit Card: ____

American Express:_____ Discover:_____ Master Card:_____ Visa:_____

Card Number: ____

Expiration Date on Card: __________ CVV Code: ____________

Payee Phone Number: ____

Billing Address on Card: ____

____

(City) (State) (Zip)

- I give Statesboro Psychiatric Associates permission to charge the above credit card for payments due after each visit, and for any balances to include charges incurred due to appointments missed or canceled without appropriate notice.

Signature of Cardholder: ____________________________ Date: ____________________

*Digital Signature

- If I have any questions about these charges, I agree to contact Statesboro Psychiatric Associates. I agree that I will not pursue a refund directly through my credit/debit card company, bank or financial institution. If any of my actions yield a charge back fro any reason, I agree to pay any and all penalty fee(s) incurred by Statesboro Psychiatric Associates. I also understand that my card information will be kept secure.

Signature of Cardholder: ____________________________ Date: ____________________
*Digital Signature

Legal Custody Information

Required only for Patients Ages 17 and under:

Does the patient live with both married parents? Yes No

If No:

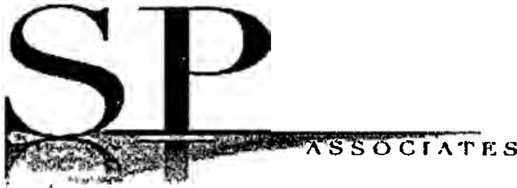
With whom does the patient live?

Who has legal custody of the patient?

If parents have joint custody, who has the medical tiebreaker?

If parents are divorced, we require a copy of the court custody order, including power of medical decision making.

If patient is in foster care and/or has a temporary guardian, we require a copy of the court custody order, including power of medical decision making.



Notice of Privacy Policies: Acknowledgment of Receipt

I have received and reviewed a copy of Statesboro Psychiatric Associates' Notice of Privacy Policies. **In addition to my emergency contacts,** I authorize Statesboro Psychiatric Associates to talk with the following parties regarding my treatment and appointments, to pick up prescriptions per my request, and bring minor children to their appointments as applicable:

Name:______________________________ Relationship:______________

Phone:(H)________________(W)________________(C)________________

Address:____

Name:______________________________ Relationship:______________

Phone:(H)________________(W)________________(C)________________

Address:____

Name:______________________________ Relationship:______________

Phone:(H)________________(W)________________(C)________________

Address:____

Name:______________________________ Relationship:______________

Phone:(H)________________(W)________________(C)________________

Address:____

- I understand that in addition, SPA can provide treatment information to other providers for the purpose of coordination of care. This includes my primary care physician, referring physician, and other health care providers involved in my care.
- In the case of a child, I understand that in many circumstances, a custodial parent or legal guardian other than the person bringing the child to appointments may have legal right to obtain the medical records of the minor.

********************YOUR SIGNATURE IS REQUIRED EVEN IF NOT LISTING ANYONE ON THE PRIVACY FORM**********************

________________________________ ________________________
Print Patient's Name Patient's Date of Birth

________________________________ ________________________
Signature of Patient * Digital Signature Date

________________________________ ________________________
Signature of Parent/Guardian/Personal Rep *Digital Signature Date