# Registration Form

## Susan M. Sexton, MA, LP

**Date**

# Patient Information

### DX Code

**Patient Name** (Print)

Last Name First Name Initial

### Date of Birth

Street Address Home Phone :

City State ZIP Work Phone :

Soc. Sec. # Emergency Contact Cell Phone :

Sex: G Female G Male Age Marital Status: G Single G Married G Partnered G Divorced G Separated G Widowed

Employer Occupation

Referred by May we acknowledge this referral?

# Primary Insurance

**Primary Insurance Company** Phone :

Ins Claims Address City State Zip

Policy / Member ID Group/Account #

**Policy Holder Information**: (if the patient is not the employee/policy holder)

Name

Last name First Name Initial

### Date of Birth

Address City State Zip Relationship Soc. Sec# Employer

# Secondary Insurance

**Secondary Insurance Company** Phone:

Ins Claims Address City State Zip

Policy / Member ID Group/Account #

**Policy Holder Information**: (if the patient is not the employee/policy holder)

Name

Last name First Name Initial

### Date of Birth

Address City State Zip Relationship Soc. Sec# Employer

***Responsible Party*** (Where should the patient’s portion of the bill be sent, if not to the patient?)

Name Relationship

Address Phone :

## Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date