

Employee Assistance

Behavioral Health Programs



& ASSOCIATES, INC.

## PATIENT REGISTRATION FORM

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone #: \_\_\_\_\_ Alternate Telephone #: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (optional) : \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Partner Other: \_\_\_\_\_ Age: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_ Email: \_\_\_\_\_

Patients Spouse or Parent (If Minor): \_\_\_\_\_ Telephone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone #: \_\_\_\_\_

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to \_\_\_\_\_ for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize Clear Solutions, LLC (contracted billing service for \_\_\_\_\_) to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Clear Solutions, LLC to sign said claim(s) or any refiled claim on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## INSURANCE INFORMATION

Company Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Policy No.: \_\_\_\_\_  
Group No.: \_\_\_\_\_ Policy Holder's Social Security No. (if different from Patient): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Policy Holder (if different from Patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

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## TO BE COMPLETED BY BILLING OFFICE

Date: \_\_\_\_\_ Spoke with: \_\_\_\_\_ Circle one:            In Network      Out of Network  
Policy Effective: \_\_\_\_\_ Co pay Per Visit: \$ \_\_\_\_\_ Coinsurance Per Visit: \_\_\_\_\_  
Deductible Amount: \$ \_\_\_\_\_ Deductible Met: \$ \_\_\_\_\_ Max Visits/Max Payable Per Year: \_\_\_\_\_  
Out of Pocket Max Per Year: \_\_\_\_\_ Exclusions to policy: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Authorization #: \_\_\_\_\_ Sessions Approved: \_\_\_\_ Authorization Date: \_\_\_\_\_ thru \_\_\_\_\_  
Notes: \_\_\_\_\_

Fill out this form electronically or by hand and EMAIL to [drgup@gupinc.com](mailto:drgup@gupinc.com)