Treeside
Psychological Clinic P.C.

Date:_____
CPT Code:_____
Dx:_____
Amount Paid: _____
Cash/Ck #: _____
Clinician:_____

Patient Registration

Patient Information

First Name _____M.I. ___ Last Name _____ S.S# _____

Address _____ City_____ State _____ Zip _____

Phone _____ Birth date: _____/_____/_____ Sex: M F Marital Status S M D W

Guarantor Information (Financial responsible party or policyholder *If other than patient*)

First Name _____M.I. ___ Last Name _____ S.S# _____

Address _____ City_____ State _____ Zip _____

Phone _____ Birth date: _____/_____/_____ Sex: M F Marital Status S M D W

Relationship to patient _____

Insurance Information (we will need a copy of your insurance cards and driver's license)

(You must fill out the policy holder information if other than self)

Primary Insurance _____Policy ID #_____ Group#_____

Policy Holder _____ Birthdate: : _____/_____/_____ Relation to patient: _____

Secondary Insurance _____Policy ID #_____ Group#_____

Policy Holder _____ Birthdate: : _____/_____/_____ Relation to patient: _____

Tertiary Insurance _____Policy ID #_____ Group#_____

Policy Holder _____ Birthdate: : _____/_____/_____ Relation to patient: _____

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that a Billing Service will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to Provider. I agree that I am ultimately responsible for full payment of this account and for all costs and fees in the collection of this account. I request the provider/billing service to release any information deemed necessary to any insurance or third party.

Patient Signature _____ Date _____

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