Sound Psychology

3515 SW Alaska Street • Seattle, WA 98126
Phone: 206-937-1481 • Fax: 206-937-6236

PATIENT REGISTRATION FORM **DX Code(s):** _____

(Please complete all areas of form and provide a copy of your insurance card(s)

PATIENT INFORMATION

Patient Name: _____ **Sex:** M [ ] F [ ]

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Email:** _____

Home: (_____) _____ **Work:** (_____) _____ **Cell:** (_____) _____

OK to leave a message at: HOME Yes [ ] No [ ] WORK YES [ ] NO [ ] CELL YES [ ] NO [ ]

SS#: _____ **Date of Birth:** _____ **Employer:** _____

Occupation: _____ **Name of Spouse/Partner:** _____

Emergency Contact: _____ **Phone#:** _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE PATIENT): _____

Responsible Party Billing Address/City/Zip Code: _____

Relationship _____ **Contact #:** _____ **SS#:** _____

PRIMARY INSURANCE

Primary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

SECONDAY INSURANCE

Secondary Insurance: _____

Claims Address: _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN

I was referred by: _____ **PCP/Phone#:** _____

I, _____, have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout. I am also responsible to pay for all missed appointments and late cancellations.

Patient and/or Guardian Signature: _____ **Date:** _____

PLEASE NOTE ALL 3 AREAS MUST BE SIGNED IN ORDER FOR OUR OFFICE TO BE ABLE TO BILL YOUR INSURANCE COMPANY

AUTHORIZATION TO BILL INSURANCE

I,_____,hereby give my consent for _____ to bill my insurance
(Name of Provider)
company _____ for services
(Name of Insurance Company)
rendered to me by the above mentioned health care provider.

PATIENT SIGNATURE:_____

ASSIGNMENT OF BENEFIT

I authorize the above mentioned insurance company to pay medical benefits directly to the above mentioned health care provider.

PATIENT SIGNATURE:_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize, _____ to release necessary medical
(Name of Provider)
information to the above mentioned insurance company and/or to their designated managed care company. _____, as is required by my
(Name of Managed Care Company)
insurance company to process my insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Date: _____

PATIENT SIGNATURE:_____

SS#:_____DOB:_____