REGISTRATION FORM

TODAY'S DATE: _____

FULL NAME OF CLIENT: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CELL PHONE: _____ **WORK PHONE:** _____

E-MAIL ADDRESS: _____

CLIENT'S BIRTHDATE: _____ **AGE:** _____ **GENDER: M / F MARITAL STATUS:** _____

CLIENT'S SOCIAL SECURITY NUMBER: _____

CLIENT'S OCCUPATION: _____ **EMPLOYER:** _____

SPOUSE'S NAME: _____ **WORK PHONE:** _____

If client is a MINOR or DEPENDENT, please complete the following section:

FATHER'S FULL NAME: _____ **DOB:** _____

FATHER'S PLACE OF EMPLOYMENT:

_____

FATHER'S E-MAIL: _____ **CELL PHONE:** _____

MOTHER'S FULL NAME: _____ **DOB:** _____

MOTHER'S PLACE OF EMPLOYMENT:

_____

MOTHER'S E-MAIL: _____ **CELL PHONE:** _____

If client is a student, what is his/her grade level? _____ **School?** _____

Guarantor Name, if different from above:

_____

Guarantor Address, if different from above:

_____

IF HEALTH INSURANCE WILL BE USED TO PAY A PART OF YOUR FINANCIAL OBLIGATIONS, PLEASE FILL OUT THE INSURANCE AGREEMENT ON THE NEXT PAGE.

800 E. Northwest Highway, Suite 106, Mount Prospect, Illinois 60056
Tel. (847) 909-9858 / Fax. (847) 299-4952

INSURANCE AGREEMENT

Most Third-Party payors (insurance companies) require the provider to release information regarding diagnosis, type and place of service rendered, dates of service, and possibly other related confidential information. Other payors may require a treatment plan and/or a periodic review of services. We are unable to control such information after it has been released and the client or responsible parties should realize that there are social and legal risks posed by the release of confidential information to Third-Party payors.

1. Managed Health Care Plans (HMO's, PPO's, EAP's) may reimburse me for professional services. Special arrangements must be made with the Managed Health Care Plan before a third party source will be accepted.
2. If you expect insurance to reimburse you for your payment, please provide the following information so we can assist you by completing the necessary forms.

A) **PRIMARY** Insurance Company: (*if different than information listed on Registration Form*)

Address: _____

Phone Number: _____ Insurance ID #: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____ Employer: _____

3. Do you know the following benefits associated with your insurance?:

Deductible $_____ Amt. Paid $_____ Amt. Owed $_____

Co-insurance %_____ Est. Amt. $_____

4. If you want this office to complete insurance forms, we need your signature to authorize release of information to the health insurance company and/or its agents.
5. Since health insurance may be used to pay a part of your obligations, this office may accept insurance as a partial reimbursement. You must authorize the insurance company to make such payments directly to Mark D. Parisi, Psy.D. & Associates, P.C. However, such an agreement does not release you from the final responsibility for the bill.

I authorize payment of my medical benefits to Mark D. Parisi, Psy.D. & Associates, P.C., for partial payment for professional services delivered, and agree to an estimated co-payment of _____ per session charge. The insurance policy's annual deductible must be met before assignment of the policy benefits will be accepted. I acknowledge full responsibility for payment of all professional fees. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to any insurance company, managed care agent, adjuster, or attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____ _____

(Signature of Client / Responsible Party) (Today's Date)

_____

(Printed Name)

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