Shelby Psychological Services

Adult Patient Registration Form

PATIENT INFORMATION					
Name		Birth Date	❒ Male ❒ Female	Social Security Number	
Street Address		City		State	Zip Code
School (if applicable)	Grade	Employer		Work Phone ( )	
Email Address				Home Phone ( )	
Primary Care Physician Name:				Cell Phone ( )	

How Did you Hear About Us?

❒ Physician ❒ Internet ❒ Yellow Pages ❒ Insurance Co. ❒ Other _____

INSURANCE INFORMATION (Please provide your insurance card for office to copy)			
Primary Insurance		Primary Policyholder's (PP's) Name	
Primary Policyholder's Social Security #	PP's Birth Date	PP's Employer	Group number
Policy Number		Patient's Relationship to Primary Policyholder	
Secondary Insurance			
Primary Policyholder's Name	PP's Birth Date	PP's Employer	Group number
Policy Number		Patient's Relationship to Primary Policyholder	
Person Responsible for Bill and address if different			

Your Signature

Acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
- Notice of HIPAA and State of Alabama policy and practices to protect your health information
- Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services
- Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog.

Authorizes:

- SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
- Consent to release treatment information to SPS providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source
- Consent to release information for insurance purposes, when required, with supervising providers.

I have read, understand and acknowledge/authorize the above.

Printed Name of Patient/Guardian_____

_____ _____

Signature of Patient/Guardian **Date**

Shelby Psychological Services
FINANCIAL AGREEMENT

Patient/Guardian/Responsible Party Name:
_____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. **APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE.** Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of $200/hour. A retainer fee of $1000 is required at the time of the request. _____Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____Date _____