



REGISTRATION INFORMATION

PATIENT NAME BIRTHDATE SEX
MARITAL STATUS SSN EMPLOYER
HOME PHONE CELL PHONE WORK PHONE
ADDRESS CITY ZIP COUNTY
EDUCATIONAL LEVEL PRIMARY CARE PHYSICIAN

SPOUSE OR PARENT (FOR PATIENTS UNDER 18) INFORMATION

NAME EMPLOYER
WORK PHONE CELL PHONE
WILL THIS PERSON BE AN EMERGENCY CONTACT? YES NO
IF NO, EMERGENCY CONTACT NAME/RELATIONSHIP
EMERGENCY CONTACT PHONE NUMBER

PERSON RESPONSIBLE FOR BILL SSN
MAILING ADDRESS CITY/STATE ZIP
HOME PHONE CELL PHONE

HEALTH INSURANCE

NAME OF INSURED DOB OF INSURED SSN
ADDRESS OF INSURED CITY/STATE
POLICY # GROUP # INSURED'S RELATIONSHIP TO PATIENT

SECONDARY INSURANCE
NAME OF INSURED DOB OF INSURED
POLICY # GROUP # INSURED'S RELATIONSHIP TO PATIENT

ARE YOU USING AN EMPLOYEE ASSISTANCE PROGRAM? YES NO
NAME OF EMPLOYER/EAP PROGRAM

OTHER CHARITY CARE ORGANIZATION

IF YOU HAVE NO INSURANCE, DO YOU WISH TO APPLY FOR A SLIDING SCALE PROGRAM? YES NO

Some medical insurance plans pay a portion of the provider's fees. You will be expected to pay your copay at the time of the visit and the portion of your bill not covered by your medical insurance at any follow up appointments or upon receipt of your monthly statement.

No Show Policy: We may bill you for part or all of appointments not canceled with 24 hours notice. Also, your provider may choose to discharge you from their care if appointments are not canceled or rescheduled in a timely manner.

PSYCHOTHERAPY CLIENTS ONLY: Veridian has granted a payment scholarship in the amount of \$ . Your responsibility per session will be \$ .

By my signature below, I authorize Veridian Behavioral Health and its agents to submit claims to my insurance company on my behalf. I also authorize Veridian Behavioral Health any payments made by the insurance company for services rendered and charges submitted.

DATE SIGNATURE OF CLIENT
WITNESS SIGNATURE OF PARENT OR LEGAL GUARDIAN