Hampton Mental Health Associates, Inc.

Patient Registration Information

Patient Name **Preferred Name:**

Address:

City **State** **Zip** **Home #:**

DOB **SSN** **Work #** **Cell #:**

Employer **Occupation**

Patient is: ⓪ **Minor** ⓪ **Single** ⓪ **Married** ⓪ **Divorced** ⓪ **Widowed** ⓪ **Separated**

By whom were you referred?

Workers Comp or Legal Issue?

Emergency Contact Name: **Phone #**

Responsible Party AND Insurance Information

Name of person financially responsible for this account if different from patient?

Address:

City **State** **Zip** **Home #:**

DOB **SSN** **Work #** **Cell #:**

Employer **Occupation**

Primary Ins. Name **Secondary Ins Name:**

Subscriber Name: **Subscriber Name:**

ID# **ID#**

Group/Plan# **Group/Plan#**

Subscriber DOB **Ph #** **Subscriber DOB** **Ph #**

Person responsible for care of Patient if a Minor

⓪ **Father**
⓪ **Mother** ⓪ **Stepfather** ⓪ **Stepmother** ⓪ **Foster Father** ⓪ **Foster Mother** ⓪ **Guardian** ⓪ **Single** ⓪ **Married** ⓪ **Divorced** ⓪ **Widowed** ⓪ **Separated**

Name: **Home #** **Cell #:**

Employer **Occupation** **Work #**

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits to which I am entitled from any insurance plan to Hampton Mental Health Associates. Please remember that insurance is a method of reimbursing the patient for services/fees paid to Hampton Mental Health Associates and is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance or any other balance not paid by your insurance within a 90 day period. Please sign below to acknowledge your agreement to these terms. I understand that should I miss my appointment without notifying the office prior to 24 business hours, I will be charged $50.00. ***Please notify the office if you do not wish to be contacted at home or work.***

Signature_____ Date_____