

Hampton Mental Health Associates, Inc.

Patient Registration Information

Patient Name

Preferred Name:

Address:

Email:

City

State

Zip

Home #:

DOB

SSN

Work #

Cell #:

Employer

Occupation

Patient is: Minor Single Married Divorced Widowed 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

Subscriber

DOB

Ph #

DOB

Ph #

Person responsible for care of Patient if a Minor

Father Stepfather Foster Father Single Divorced
 Mother Stepmother Foster Mother Guardian Married Widowed 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 _____