COASTAL PSYCHOLOGY & EDUCATION SERVICES, LLC
REGISTRATION

Please Print

Date _____ Home Phone # _____
Client _____
SS # _____

Address _____
City_____State _____ Zip _____ E-mail: _____
Cell _____

Age _____ DOB _____ Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Employed ☐ Full-Time Student ☐ Part-Time Student School Name _____

If Client is a Minor, please complete. If address/phone is different from minor, please list:
Mother _____
Father _____
Who is Responsible/Insured for this account _____

Primary Care Physician _____ Phone# _____

Client Employed by _____
Occupation _____
Business Address_____ Bus. Phone _____

Spouse or Responsible Party _____ DOB _____

SS# _____ Occupation _____Employer _____

Do you have Medical Insurance? ☐ No ☐ Yes Name of Insurance _____

Name of **Insured** _____SS# _____ DOB _____

Subscriber ID# _____ Contract # _____ Group # _____

Name of Secondary Insurance _____Insured's Name _____

ID# _____Contract # _____Group # _____ SS #_____DOB _____

Are you covered under any of these programs? ☐ Medicare ID# _____ ☐ Workers Comp.
If your condition related to employment (current or previous) ☐ No ☐ Yes _____
Is your condition related to an auto accident? ☐ No ☐ Yes In which state _____
Other Accident? ☐ No ☐ Yes Please describe _____

WHO REFERRED YOU TO US? _____

Emergency Contact: _____

Home Phone _____ Cell/Work Phone: _____ Relationship _____

Please list other physicians, psychiatrists, psychologists or therapists you have seen in the last five years:

1. _____ City/State _____

Reason for visits: _____

2. _____ City/State _____

Reason for visits: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
(Name of Insurance Company)

And assign directly to Dr. _____

Mental Health benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether by paper or electronic.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to prepare the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes release of the information to the insurer or person shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

All health information will be mailed to your home address as listed on the Registration Form unless otherwise noted. All reasonable requests to receive communication of your health information by alternative means or alternative locations will be granted as outlined below. Please check one of the following:

____ Please send all information to the home address as listed on page 1 of the Registration Form

____ I wish to receive my information at an alternative location or through alternative means. Please describe the alternative means (e.g. U.S. Mail, telephone call, etc. and list address and telephone number) _____

_____

_____

_____ _____
Signature Date