Affinitas Psychiatric Care, PC
Registration Form

Demographic Information

Name: _____ _____
Last Name First Name MI Preferred Name

Gender: Male Female DOB: _____ SSN: _____

_____
Mailing address City State Zip Code

_____ _____
Home Phone Cell Phone

Email address _____

Initial each if applicable: I consent to email communications from: my provider _____ billing staff _____
Initial each if applicable: I **DO NOT** consent to email communications from: my provider _____ billing staff _____

Employer: _____ Work Number: _____

Emergency Contact Name: _____ Phone: _____

Insurance & Billing

Responsible Party (minors only): _____ DOB: _____

Contact Number: _____ SSN: _____

Referring Provider: _____ Provider NPI: _____

Primary Insurance	Secondary Insurance
Name of Insurance _____	Name of Insurance _____
Subscriber ID # _____	Subscriber ID # _____
Group # _____	Group # _____
Insurance Phone number _____	Insurance Phone number _____
Policy Holder Name _____	Policy Holder Name _____
Policy Holder DOB _____	Policy Holder DOB _____

I agree to release of medical or other information to process claims. _____ Initials
I agree to accept assignment of payment. _____ Initials
I give permission to leave a message via voicemail. _____ Initials

I give permission to discuss my billing account with: _____

I understand that it is my responsibility to verify that my provider is in-network, obtain any referrals and/or prior-authorizations that may be required. I understand that, although insurance may or may not cover part of my charges, I am responsible for payment, and I authorize payment of my insurance to be paid directly to the provider.

_____ _____ _____
Name (Printed) Signature Date