ClearInsight Psychiatry, Inc. PATIENT REGISTRATION INFORMATION

Primary Care Physician: Referring Physician/Psychologist/Therapist: How did you hear about us: Internet Ad Others Preferred Pharmacy Name, Location, Phone if known: Emergency Information Name of Emergency Contact: Emergency Telephone () Insurance Information Primary Insurance: Social Security Number: Subscriber Name: Group Number: Identification Number: ASSIGNMENT OF BENEFITS AND RECORDS RELEASE ASSIGNMENT OF BENEFITS ASSIGNMENT OF BENEFITS I hereby authorize direct payment to ClearInsight Psychiatry, Inc. I also understand that it is my responsibility to obtain my required referral authorization prior to my appointment time. I am also responsible for any co-payment, deductible, or patien portion on the day of service. I understand that if my account becomes delinquent, I wil be held responsible for reasonable attorney's fees, court costs, and collection costs. MEDICAL RECORDS RELEASE I hereby authorize ClearInsight Psychiatry, Inc. to release my records to my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by the payer. *Patient Signature Date: For Office Use Only	Name:	Date of Birth:_	/ Sex: Male Femal	e
Home Telephone: ()	Home Address:			
Home Telephone: ()	City:	State:	Zip Code:	
Cell Phone:(E-Mail Address: Decupation: Primary Care Physician: Referring Physician/Psychologist/Therapist: How did you hear about us: Internet Ad Others Preferred Pharmacy Name, Location, Phone if known: Preferred Pharmacy Name, Location, Phone if known: Preferred Pharmacy Name, Location, Phone if known:	Home Telephone: ()			
Employer: Occupation: Primary Care Physician: Referring Physician/Psychologist/Therapist: How did you hear about us: Internet Ad Others Preferred Pharmacy Name, Location, Phone if known:	Cell Phone:()	E-Mail Address:		
Primary Care Physician: Referring Physician/Psychologist/Therapist: How did you hear about us: Internet Ad Others Preferred Pharmacy Name, Location, Phone if known:	Employer:	0	ecupation:	
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Insurance Information Primary Insurance:	Emergency Information			
Insurance Information Primary Insurance:	Name of Emergency Contact:		_ Relationship to Patient:	
Primary Insurance: Subscriber Name: Group Number: Group Number: Secondary Insurance: Social Security Number: Secondary Insurance: Social Security Number: Social Se				
Subscriber Name: Group Number: Identification Number: Secondary Insurance: Social Security Number: Subscriber Name: Date of Birth: Date of Bi	Insurance Information			
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Group Number:				
Subscriber Name:				
Subscriber Name:	Secondary Insurance:	Soc	ial Security Number:	
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*Patient Signature Date:				
For Office Use Only				
For Office Use Only	*Patient Signature		Date:	
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Rev. 11/2022 ClearInsight Psychiatry, Inc.