ClearInsight Psychiatry, Inc.
PATIENT REGISTRATION INFORMATION

Name:_____ Date of Birth:___/___/____ Sex: Male Female
Home Address:_____
City:_____ State:_____ Zip Code:_____
Home Telephone: ( )_____Work Telephone: ( )_____
Cell Phone:( )_____E-Mail Address:_____
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:_____

Emergency Information
Name of Emergency Contact:_____ Relationship to Patient:_____
Emergency Telephone ( )_____

Insurance Information
Primary Insurance: _____Social Security Number:_____
Subscriber Name:_____ Date of Birth:____/___/_____
Group Number: _____Identification Number:_____
Secondary Insurance: _____Social Security Number:_____
Subscriber Name: _____Date of Birth:____/____/_____
Group Number: _____Identification Number:_____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE
ASSIGNMENT OF BENEFITS
I hereby authorize direct payment to ClearInsight Psychiatry, Inc of any medical benefits payable to me for services provided at 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 patient portion on the day of service. I understand that if my account becomes delinquent, I will 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 company and/or primary care physician for the purpose of processing 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
CURES:_____Copay: $_____Insurance Name:_____ Authorization/Visit:_____
