MOHANDESSI PSYCH, LLC

833 SW 11TH AVENUE, SUITE 214
PORTLAND, OREGON 97205
PHONE: (503) 481-9441 FAX: (503) 224-5951

PATIENT REGISTRATION FORM

Demographic Information

Name: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Billing Address (if different from above): _____
Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Social Security Number: _____ Referral Source: _____
Date of Birth: _____
Gender: F M
Marital Status: _____
Emergency Contact Person: _____
Contact Relationship: _____
Contact Phone: _____

Payment Method

__ Cash __ Check __ Debit __ Credit

Name of Credit Card Holder: _____
Credit Card Type: _____
Credit Card Number: _____
Expiration Date: _____
Security Code: _____

This information will be kept on file as a back-up payment method unless otherwise specified by the client. The client agrees to keep this information up-to-date and inform Mohandessi Psych of any changes. Mohandessi Psych will retain this information in a confidential manner and not disclose any information to a third party except for as necessary to conduct the agreed upon services.

Insurance Information

Mohandessi Psych, LLC will bill your medical insurance company for services rendered. You are responsible for any fee, co-pay, or co-insurance at the time of your appointment. Any charges within your insurance deductible will also be your responsibility to pay at the time of service. In addition, if your insurance does not pay for the services rendered, you will be responsible to pay your balance within 30 days of receipt of an invoice from Mohandessi Psych. LLC. If you do not pay within 30 days of the date of service or invoice, you will be charged a $100 late fee and be subject to 1.5% monthly interest on any outstanding balance. Your insurance will not pay for these charges nor will they pay for missed appointments.

Insurance Carrier: _____

Policyholder's Name: _____DOB: _____ SSN: _____

Relationship to Insured: Self Spouse Child Other _____

Policy Number: _____

Plan Name: _____

Group Name: _____

Expiration Date: _____

Customer Service Number: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE AND ANY OUTSTANDING BILL FOR SERVICES RENDERED.

_____

Patient Name—Print

_____ _____

Patient Signature or Responsible Person Date

_____

Relationship to Patient