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PATIENT REGISTRATION FORM
(Please Print Clearly)

Name: _____ DATE: _____

DOB (birth date): _____ SSN: _____

Address: _____
(Number, Street, Box, Apt, Space) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

What phone number should we call to reach you ? _____

Emergency Contact (name and phone) _____

Employer: _____
(Name) (Address)

Referred By: _____ Family Physician _____

Current Medication(s): _____

RESPONSIBLE PARTY:

NAME: _____

DOB: _____ Relationship to patient _____

Address: _____
(Number, Street, Box, Apt, Space)

SSN: _____ Home Phone: _____ Work Phone _____ Cell Phone: _____

Noncustodial Parent, if any: _____
(Name) (Address)

SSN: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

WE DO NOT FILE OR BILL INSURANCE.

PLEASE READ AND SIGN OTHER SIDE (Page 2)

FINANCIAL POLICIES

- Payment is due and expected at the time of service. Personal checks, cash, and Visa/MasterCard are accepted. There is a \$25 charge for returned checks.
- There is a charge for appointments missed, changed or canceled with less than 24 working hours notice.
- Due to the extra time and case review needed, there is a charge for extended or complex phone calls, and for letters, reports, or authorizations done on your behalf for other clinicians or insurance companies or at your request.
- Delinquent accounts will be subject to a 1.5% interest charge per month. I further agree, that should my account be turned over to a collection agent, I will be responsible for any and all charges incurred as a result of the collection process. If temporary financial problems arise, please contact office billing staff so that an adequate payment plan may be arranged.
- Each therapist/doctor at 1980 E. Fort Lowell Road, Suite 150 has a separate practice. This is not a group practice or partnership. Please be aware that there exists only an office sharing arrangement and that no partnership exists. Dr. Leehey's clinical practice is fully independent of all persons, agencies, and he is a sole proprietor.
- We do not file or bill insurance. Your insurance coverage is a contract between you and your insurance carrier. You are responsible for all charges incurred. We provide a superbill to assist you in your filing for any available reimbursement with your insurance company.
- I hereby authorize the release of any and all information necessary for Dr. Leehey to provide or coordinate care on my behalf. This release of information will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original. I understand that I am responsible for all charges whether or not authorized and paid by my insurance. If the patient is a dependent or minor I/we agree to be responsible for all clinical charges incurred by the patient.
- HIPAA is a federal law governing internet related billing transactions. HIPAA is intended to improve such electronic transactions and enhance privacy. Dr. Leehey does not perform such electronic transactions which frees you from reading and signing HIPAA forms and notices. Dr. Leehey's practice meets or exceeds HIPAA privacy standards.
- I have read, understand, and agree to this sheet of policies. I have also read and agree to Dr. Leehey's practice information brochure detailing office policies.

Signature

Date