# *Patient Registration Form*

| First Name: | Last Name: | M.I.: |
|---|---|---|
| Address: | | |
| City: | State: | ZIP: |
| Home Phone: | Work Phone: | |
| Birth Date: / / | Age: | Social Security #: - - | Sex: M F |

***If the patient is a minor, please fill in the parent's name and work telephone numbers below.***

| Father's Name: | Mother's Name: |
|---|---|
| Father's Work Phone: | Mother's Work Phone: |

**INSURANCE INFORMATION:** If you are covered by more than one insurance company, the insurance which is in your name is your primary insurance. The insurance which is in your spouse's name is your secondary insurance. If you are covered by only one insurance company, then that is your primary insurance.

| **Primary Insurance Company** | **Secondary Insurance Company** |
|---|---|
| Ins. Co. Name: _____ | Ins. Co. Name: _____ |
| Ins. Address: _____ | Ins. Address: _____ |
| _____ | _____ |
| Ins. Phone #: _____ | Ins. Phone #: _____ |
| Group #: _____ | Group #: _____ |
| ID#: _____ | ID#: _____ |
| Subscriber's Name: _____ | Subscriber's Name: _____ |
| Subscriber's DOB: | Subscriber's DOB: |

| Who referred you to my office: | I authorize Elena Ramirez, Ph.D., to send a summary of my initial evaluation to my referring doctor or therapist. |
|---|---|
| ☐ Doctor ☐ Therapist ☐ Other | |
| Name: _____ | Signed: _____ Date: / / |

| If the person responsible for the bill is not the patient, please fill in this section: | | |
|---|---|---|
| Person responsible for bill: | | Their phone #: |
| Their address: | | |
| City: | State: | ZIP: |

**MISSED AND CANCELED APPOINTMENTS:** There will be a $ 105 charge for appointments that are missed or canceled with less than 24 hours prior notice. Cancellations should be made by TELEPHONE.
Patient's Signature: _____ Date: / /

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits to be paid directly to Elena Ramirez, Ph.D., and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance. I authorize a copy of this registration be given to Claims Connection to bill my insurance.
Patient's Signature: _____ Date: / /

***Elena Ramirez, Ph.D.***