

Colleen A. Blanchfield, M.D.

PATIENT REGISTRATION FORM

Patient Information:

- 1.) Patient's Legal Name _____ Sex _____
- 2.) Patient's SS#¹ _____ Patient's DOB _____
- 3.) Patient's Home Address _____
- 4.) Home Phone # _____ Cell Phone # _____ Fax # _____
- 5.) Employer's Name _____ Position _____
- 6.) Work Address _____ Work Phone # _____
- 7.) Referring Doctor _____ Doctor's Phone # _____

**Guarantor Information for ALL Minor Patients, Unemployed Patients, and Patients
Needing Assistance in Completing this Form (Who is responsible for your payments):**

- 1.) Guarantor's Legal Name _____
- 2.) Guarantor's SS#² _____ Guarantor's DOB _____
- 3.) Guarantor's Address _____
- 4.) Guarantor's Home Phone # _____ Guarantor's Cell Phone # _____
- 5.) Guarantor's Employer's Name _____ Work Phone# _____

Note: In separation and/or divorces cases, in which your spouse or your spouse's family member is the guarantor, if we have not been notified of such occurrence in writing at our office, then both the patient and the guarantor are liable for payment of services until we are notified. When we are notified of such separation/divorce, we will then first bill the patient for full payment of any amounts due for prior services. Such guarantor will not be responsible for services rendered after the notification date, and they will not be billed for such services.

¹ Please provide the social security card for us to copy

² Please provide the guarantor's social security card for us to copy

Health Insurance Information (If this information changes, please call us ASAP)

1. Primary Insurance Co. _____ Phone# _____
2. Ins. Co's. Claims Address _____
3. Subscriber's Name _____ DOB _____
4. Subscriber's SS# _____ Relationship to Patient _____
5. Policy ID#³ _____ Group # _____
6. Secondary Insurance Co. _____ Phone# _____
7. Ins. Co's, Claim's Address _____
8. Subscriber's Name _____ DOB _____
9. Subscriber's SS# _____ Relationship to Patient _____
10. Policy ID #⁴ _____ Group # _____

Emergency Contact Information

1. Name _____ Relationship to Patient _____
2. Home Address _____
3. Home Phone # _____ Cell Phone # _____
4. Work Phone # _____ Work Address _____

Confidentiality

To provide you with the appropriate care, we may need to consult with others. The confidentiality of the work that we do together with you is upheld; however there are exceptions to the rule:

1. If we suspect that child abuse has occurred, the law requires that it be reported to the authorities.
2. If we believe that you are in imminent danger to yourself or another person, we may notify others to attempt to prevent that occurrence.

³ Please provide the primary insurance card for us to copy

⁴ Please provide the secondary insurance card for us to copy

3. If it becomes necessary to contact an attorney or a collection agency to collect amounts you owe this practice, then your name, information about how to reach you, the amount owed, and the reasons for the amount owed becomes available, and if court action is necessary, it may become public record.
4. In legal proceedings, the patient/doctor communications are privileged with the following exceptions:
 - If your mental status is an issue for the court
 - If the doctor is deposed, and your attorney does not take the necessary legal action to stop the deposition
 - If the judge feels that communications are necessary to the proper administration of justice.
5. If you are a participant in an HMO or a Managed Mental Health Care Company, they may require completion of outpatient treatment reports, then summaries will be provided upon request.
6. If you are to be admitted for hospitalization or in-patient treatment, your insurance company may require that we share our findings in order to get authorization for such services.
7. If you are a Medicare or Tricare policyholder, we file your primary insurance claims for all services, and in so doing, will provide details of such services, and we will accept payments from them for such services.
8. If we have not been paid for our services, we contact your insurance companies to determine if they have paid you for the services we rendered. By signing this document, you are releasing us to discuss the services with the insurance companies, and you are releasing the insurance companies to discuss their claim payments (to you or us) with us.

Authorization and Financial Agreement

I have reviewed the separate Authorization and Financial Agreement and my signature thereon evidences my acceptance of the policies therein.

Acceptance

I have reviewed this document and understand the policies described herein. My signature below evidences my acceptance of such policies.

Patient_____

Date_____

Guarantor_____

Date_____