Behavioral Diagnostics & Treatment

Patient Registration Form

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Patient's Name: _____ Responsible Party Name: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Other _____

Address: _____ City: _____ Zip: _____

Preferred Phone: _____ Alternative Phone #: _____

Responsible Party's Email Address: _____@_____

☐ YES: I give permission to use email to exchange information necessary for ongoing care.

☐ YES: I give permission to send reports to you via email.

Patient Date of Birth: ____-____-____ Age: ____ Gender: ☐ Male ☐ Female ☐ Other (_____)

Patient's Employer or School: _____ Phone #: _____

Patient's Emergency Contact: _____ Phone #: _____

Primary Insured Subscriber: _____ Primary Insurance Co.: _____

Primary Insured ID Number: _____ Primary Group #: _____

Primary Insurance Address: _____ City: _____ Zip: _____

Secondary Insured Subscriber: _____ Secondary Ins. Co.: _____

Secondary Insured ID Number: _____ Secondary Group #: _____

Secondary Ins Address: _____ City: _____ Zip: _____

Who made the referral to Forster Fulop? _____

☐ YES ☐ NO: Information may be shared related to your care with the provider who referred you.

Authorization to Release Information For Billing Purposes:

☐ I hereby authorize the above provider(s) to furnish my insurance company with any/all information requested about my present claim.
☐ I hereby authorize the above provider(s) to bill my insurance company, on my behalf for services from time to time, related to my care.
☐ I acknowledge that I am responsible for all charges incurred in this therapy or assessment process.
☐ I understand that if there is an overpayment on my account, it will be refunded to the party who had paid in excess of the bill.
☐ If I'm over 18 and a parent is paying for services, I will allow provider access to financial and other information needed to process the claim.

_____ _____ _____ _____
Patient's Signature Date Responsible Party Signature Date

Office Use Only:

☐ New ☐ Updated ☐ Bill Insurance ☐ Bill Patient
☐ Evaluation Diagnoses Codes _____ _____ _____
☐ Insurance Payment to Doctor
☐ Insurance Payment to Patient

☐ AF ☐ AC ☐ MF