

Russel Thompson, PhD
7400 Blanco Rd, Suite 126
San Antonio, TX 78216
Office: 210-699-8700
Fax: 210-587-2454

Patient Registration Information

Patient Name: _____, _____ Sex: M [] F []
Last First Middle

Date of Birth: _____ Home Phone: () _____ Cell/Work Phone: () _____

Address: _____ City: _____ State _____ Zip _____

Please check if we may leave a message on your Home Phone? Cell Phone?

If Patient is a Minor below the age of 18:

Guardian's Name: _____ Cell/Work Phone: () _____

In Case of Emergency, Please Notify: Name: _____ Relationship _____ Phone Number () _____

Chose Clinic Because/Referred to Clinic by (Please check one box)

- Dr. _____ Insurance Plan Hospital Family/Friend Convenient location Yellow Pages
 Other: _____

Payment (check one)

- I will pay for these services directly and do not wish to have you my bill insurance.
 Please bill my insurance using the following information

INSURANCE INFORMATION

Patient's SS#: _____

Primary Insurance Name: _____ Name of Insured: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

ID or Policy Number: _____ Group Number: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: () _____

Secondary Insurance Name: _____ Name of Insured: _____

Id or Policy Number: _____ Group Number: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

____ (initials) I authorize Russel Thompson, PhD & the above insurance provider(s) to release any information required to process my claims.

Cancellation Policy

____ (initial) Failure to cancel an appointment within 24 hours of the scheduled time is considered a "No-show" and is billed at the full rate. I understand that insurance usually does not pay for no-shows, and I will be responsible for the fee myself.

Authorization of treatment and payment

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Russel Thompson, PhD. I understand that I am financially responsible for any balance.

Signature: _____ Date: _____

Print Name: _____