Russel Thompson, PhD
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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: _____