MISSION PSYCHOLOGY

PSYCHOLOGICAL ASSESSMENT & TREATMENT

7400 Blanco Rd., Ste 126 | San Antonio, TX 78216
T: 210-699-8700 F: 210-587-2454 missionpsychology.com

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 (___)_____

Choose 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 Mission Psychology & 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: _____