Cleveland Psychiatry Associates LLC
6909 E Royalton Road, Ste 201
Brecksville, Ohio 44141
Phone: (440) 630-9426 Fax: (440) 630-9129

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name_____ First Name _____ Middle Initial _____

Date of Birth: _____ Gender _____ SS#: _____

Marital Status: _____ Email Address _____

Address _____ City_____

State: _____ Zip Code: _____

Phone: (H) _____ (C) _____ (W) _____

Preferred contact to confirm your appointments (circle one): Home / Cell / Work / Email

May we leave messages at this number (circle one): Yes / No

Employment Status _____ Employer Name _____

Employer Address _____

Student: *Full-time / Part-time* Name of School _____

EMERGENCY CONTACT

Last Name _____ First Name _____ Middle Initial _____

Relationship with patient _____ Best Phone # _____

May we leave a message with them: *Yes / No*

PRIMARY INSURANCE INFORMATION:

Name of Insurance _____ Effective Date _____

ID# _____ Group #_____ Phone # _____

Address for Claims _____

Is pre-authorization required for your insurance? *Yes / No*

Have you obtained authorization for this visit? *Yes / No*

Do you owe a co-pay/co-insurance amount? *Yes / No* How much? _____

INSURANCE POLICY HOLDER

Last Name_____ First Name _____ Middle Initial _____

Date of Birth: _____ SS#: _____ Phone # _____

Address_____ City: _____

State: _____ Zip Code_____ Relationship with patient _____

Employer Name _____ Phone _____

Employer Address _____

SECONDARY INSURANCE INFORMATION (If applicable):

Name of Insurance _____ Effective Date _____

ID# _____ Group #_____ Phone # _____

Address for Claims _____

Is pre-authorization required for your insurance? Yes / No

Have you obtained authorization for this visit? Yes / No

Do you owe a co-pay/co-insurance amount? Yes / No How much? _____

INSURANCE POLICY HOLDER

Last Name_____ First Name _____ Middle Initial _____

Date of Birth: _____ SS#: _____ Phone _____

Address_____ City: _____

State: _____ Zip Code_____ Relationship with patient _____

Employer Name _____ Phone _____

Employer Address _____

GUARANTOR INFORMATION (FINANCIALLY RESPONSIBLE PARTY)

Last Name_____ First Name _____ Middle Initial _____

Date of Birth: _____ SS#: _____ Phone # _____

Address_____ City: _____

State: _____ Zip Code_____ Relationship with patient _____

Employer Name _____ Phone _____

Employer Address _____

Guarantor Signature _____ Date _____

I acknowledge that all information provided above is true and accurate. I understand that my insurance information is being verified and that I may be billed as self-pay if I fail to provide accurate insurance information. I understand that the returned check will be subject to fees. I understand that I will be charged for appointments cancelled with less than 24 hours' notice and for appointments that I fail to cancel and/or show up for. I understand that any accounts placed for collections will incur a late fee. I acknowledge that I have been informed of my rights of privacy and am authorizing treatment.

Signed _____ Date _____