JANE WHITAKER, LCSW　　　　DX: ________

NEW PATIENT REGISTRATION FORM

TODAY'S DATE____________________

PATIENT'S NAME____DATE OF BIRTH_________________ M F

HOME PHONE___________________ CELL PHONE_________________________ WORK PHONE ____________________

ADDRESS____

CITY ____________________________________ STATE _________ ZIPCODE ______________

REFERRED BY ____

INSURANCE INFORMATION

INSURANCE COMPANY NAME____

ADDRESS____

CITY_____________________________ STATE _________ ZIPCODE______________

PHONE NUMBER ____

SUBSCRIBERS NAME ____

RELATIONSHIP TO PATIENT ____

ID#______________________________GROUP/POLICY #__________________________

EMPLOYER/ GROUP NAME ____

SECONDARY INSURANCE INFORMATION (if applicable)

INSURANCE COMPANY NAME__________________________________

PHONE NUMBER____

SUBSCRIBERS NAME ____

RELATIONSHIP TO PATIENT____

ID#___________________________GROUP/POLICY #________________

EMPLOYER/ GROUP NAME____

I hereby authorize Jane Whitaker, LCSW, to apply on my behalf for covered services rendered by them. I request payment from ___________________________ be made to Jane Whitaker, LCSW. (insurance company name)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to the above named insurance company in order to determine to which of their benefits I may be entitled.

This authorization may be revoked by me or my insurance company at anytime in writing.

I UNDERSTAND THAT I WILL BE BILLED FOR ANY APPOINTMENT THAT I DO NOT CANCEL WITH 24 HOURS NOTICE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

____ ___________________________

Signature of Patient/Subscriber　　　　Date