REGISTRATION INFORMATION
(Please Print)

Date:_____

Patient: _____
Last Name First Name Initial Suffix Title

Patient Social Security Number:_____

AKA: _____ **Maiden:** _____

Street Address: _____

City:_____ **State:**_____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Date of Birth: _____ **Gender:** _____ **Email:** _____

Check Appropriate Box:

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced** ☐ **Under Eighteen Years**

Referral/PCP: _____ **Responsible Party:**_____

Patient's Employer: _____

Employer Address: _____

Spouse (if applicable):_____

PRIMARY INSURANCE INFORMATION (Policy Holder)	**SECONDARY INSURANCE INFORMATION (Policy Holder)**
Insurance Co:	**Insurance Co:**
Policy Holder:	**Policy Holder:**
Policy Holder SSN#:	**Policy Holder SSN#:**
DOB: **Gender:** ☐ **Male** ☐ **Female**	**DOB:** **Gender:** ☐ **Male** ☐ **Female**
ID Number:	**ID Number:**
Group Number:	**Group Number:**
Employer (include address):	**Employer (include address):**
Deductible: **Co-Pay:**	**Deductible:** **Co-Pay:**
Number of Visits Per Year:	**Number of Visits Per Year:**
Authorization No: **# Visits**:	**Authorization No:** **# Visits**:

REGISTRATION INFORMATION
(Please Print)

MEDICARE AUTHORIZATION

I request payment of authorized Medicare benefits be made by either to me or on my behalf to Aracoma Smith, LCSW, PLLC for any services furnished me by any provider employed by Aracoma Smith, LCSW, PLLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim form or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature:_____ Date:_____

INSURANCE AUTHORIZATION

I request that payment of the authorized insurance benefits made by either to me or on behalf to Aracoma Smith, LCSW, PLLC for any services furnished to me by any provider employed by Aracoma Smith, LCSW, PLLC. I authorize any holder of medical information about me to release to the appropriate insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the insurance carrier.

Beneficiary Signature:_____ Date:_____

Emergency Contact Name: _____

Address: _____

City: _____ **Relationship:** _____

State: _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

PARENT/GUARDIAN INFORMATION

FATHER/GUARDIAN	MOTHER/GUARDIAN
Name:	**Name:**
Address:	**Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Social Security #:	**Social Security #:**
Home Phone:	**Home Phone:**
Work Phone:	**Work Phone:**
Employer:	**Employer:**
Email:	**Email**

Who does patient reside with? ☐ **Father** ☐ **Mother** ☐ **Other**

Who is financially responsible for this account: _____ **Relationship to Patient:** _____

What is the best way to reach you if I need to cancel an appointment: _____

Please note any additional information: _____

_____