Registration Form

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PATIENT INFORMATION-Please complete one registration form for each patient

Last Name	First		Middle Initial
Street Address			
City	State		Zip
Date of Birth	Sex M F	Social Security #	
Marital Status		Occupation	Work Phone
Home Phone	Cell Phone	Email	
If Minor, Legal Guardian:		Phone	
Emergency Contact	Relationship	Phone	

INSURANCE INFORMATION-Please include a photocopy of front and back of your insurance card with this registration form

Primary Insurance Co		Ins Co Phone	
Policy/ID Number		Subscriber Name	
Subscriber Date of Birth		Deductible Amount Met? Yes No	Co Pay Amount $
Relationship to Patient		Subscriber Social Security	
Is patient covered by this policy?		Effective Date of Policy	
Is authorization required?		Authorization Number(s) (include all authorization letters)	
Secondary Insurance Co		Co-pay Amount	
Policy/ID Number		Relationship to Patient	
Subscriber Employer		Employer Phone	
Employer Address			

AUTHORIZATION AND ACKNOWLEDGEMENT

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Rosemarie Calleros, PhD, LMFT to release any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Rosemarie Calleros, PhD, LMFT all my rights, title, and interest to medical reimbursement benefits under my insurance policy. I acknowledge and agree it is my responsibility to know my eligibility and benefits, including co-pay & deductible amounts, covered benefits, and obtaining authorization prior to treatment. I acknowledge and agree I am financially responsible for payment in full to Rosemarie Calleros, PhD, LMFT for any services not covered by my health insurance for any reason. I acknowledge and agree I am financially responsible for any balance attributed to "patient responsibility" including, but not limited to co-pay, deductible and/or co-insurance. I acknowledge and agree that by signing this form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient/Legal Guardian Signature _____ **Date** _____

Email: rmcallerosphd@cox.net