Patient Registration Form

Michael Jokich, LCSW

Cohesive Pathways, P.C.

Today's Date: ____ Dx Code(s): __________________________
(please leave blank)

PATIENT INFORMATION

Patient Name: ____ Sex: M [ ] F [ ]

Street Address: ____

City: ____ State: ________ Zip Code: _________________

Home: (_______)_____________________________ May I call this number? Y N Leave a message? Y N

Work: (________)_____________________________ May I call this number? Y N Leave a message? Y N

Cell: (_________)____________________________ May I call this number? Y N Leave a message? Y N

Email: _______ _______________________________

SS#:__________________________________Date of Birth: ______________ Employer:___________________________

Occupation:___________________________ Name of Spouse/Partner (if applicable): ___________________________

Person to contact in event of emergency: ___________________________________ Phone#: ____________________

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT): ____

Billing Address with City/Zip Code: ____

Phone# Hm:_________________ Wrk: _____________________ Relationship to patient: ______________________

Employer: ____ SS#:___________________________________

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

Name of Insurance Company:____

Address of Ins Co.: ____

Subscriber:____ Relationship to patient: ___________________

Policy#: ____________ Group#: _____________________ ID#: ____

Is this a managed care plan? YES [ ] NO [ ] *If no, skip to the next section*

Have you obtained authorization? YES [ ] NO [ ] Do you have a referral from your primary physician? YES [ ] NO [ ]

Name of Managed Care Company: ________________________________ Phone#_______________________

Name of Primary Physician: _____________________________________ Phone #_______________________

REFERRAL SOURCE

Name of person referring you to this office: ____

May I thank this person for referring you? YES [ ] NO [ ]

SIGNATURE/AGREEMENT

I,____ , have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout.

Patient and/or Guardian Signature:____ Date: ______________

Authorization to Bill Insurance

Michael Jokich, LCSW
Cohesive Pathways, P.C.

Please fill out this page if you intend to use health insurance coverage to pay for psychotherapy services.
If you are not using health insurance to pay, please leave this page blank.

I, ____, hereby give my consent for the following actions in order to submit claims for psychotherapy services to my insurance company:

1. AUTHORIZATION TO BILL INSURANCE

I give consent for Michael Jokich, LCSW and/or Cohesive Pathways, P.C. to bill my insurance carrier for services rendered to me by Michael Jokich, LCSW.

Name of insurance carrier: _________________________________

2. ASSIGNMENT OF BENEFIT

I authorize the above mentioned insurance carrier to pay medical benefits directly to the above - mentioned provider/entity.

3. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Michael Jokich, LCSW and/or Cohesive Pathways, P.C., to release such medical or other information to the above-mentioned insurance carrier and/or their designated managed care company, as is required by my insurance carrier to process said billings.

Name of Managed Care Company____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Patient and/or Guardian Signature: ________________________________ Date: _______________

SS#: ____ DOB: _______________

Witness Signature: ____ Date: _______________