House Psychiatric Clinic- Registration & Insurance Form

In order to complete this form, you will need to call your insurance company's customer service line and speak with a representative.

Patient's Name: _____

Date of Birth: _____

Gender: Male___ Female___

Address: _____

_____

Guardian's Name (if patient is a minor): _____

Phone Number: _____

Emergency Contact: _____

Phone Number: _____ Relationship to Patient: _____

Will you be using insurance? Yes___ No___

Social Security Number (Required if using insurance): _____

What is your insurance company? _____

Insurance ID: _____ Group Number: _____

Plan Name: _____

Name of subscriber on your insurance plan: _____

What is the subscriber's relationship to the patient? _____

Subscriber's Social Security Number: _____ Subscriber's Date of Birth: _____

Subscriber's Employer (Company Name): _____

Does your insurance company have a different company that handles your mental health benefits? If so, what is the company? **(This is called a "mental health carve-out" and is how most people end up owing more money than they expect. We are in network with many carve-out companies, but not all of them.)** To find this out, please ask the customer service rep where our office would send your mental health claims, and write the name of the company below.

Name of Mental Health Carve-Out Company: _____

Address: _____

Do you have a deductible? Yes___ No___ If yes, what is the deductible? _____

Do you have a copay? Yes___ No___ If yes, what is the amount per visit? _____

Do you have co-insurance? Yes___ No___ If yes, what is the amount per visit? _____

Does your insurance require preauthorization/registration for mental health services? Yes___ No___

If yes, write authorization number here: _____

How many visits does this authorization allow? _____

What is the start date for the authorization? _____ What is the end date? _____

How many visits are you allowed if you have a parity (severe) diagnosis? _____

How many visits are you allowed if you have a non-parity (not severe) diagnosis? _____

Please sign your name to one of the following:

I understand that it is my responsibility to obtain initial authorization from my insurance company (if authorization is required) if using insurance, and any time there is an insurance change. I understand that I am responsible for all charges, regardless of insurance coverage. I understand my copay/deductible amount/coinsurance is due at the time of service.

Sign here: _____

I understand that I am paying privately for services rendered, and not utilizing insurance. I understand that I am responsible for all charges in full. If I later submit this claim to an insurance company, House Psychiatric Clinic will not be liable for any contractual reductions I might be entitled to receive.

Sign here: _____