

Virginia D Reiber PhD CGP

781 329 1159

REGISTRATION FORM

Name: _____ Date of Birth: _____ Sex: ___ M ___ F Marital Status: _____

Address: _____ City _____ State _____ Zip _____

Patient Bills to: _____ Address (If different) _____

Home Phone: _____ Number that messages may be left at : _____

Client Soc. Sec # _____ Client Employer: _____

Emergency Contact Name: _____ Contact Phone: _____

Referred By: _____ Primary Care Physician _____

Family Members/Others Living in Home

<u>Name</u>	<u>Relationship to Client</u>	<u>Date of Birth</u>	<u>Occupation</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSURANCE INFORMATION

**Attach Copy of Insurance Card (front and back)

Primary:

Name/Type: _____

Subscriber Name _____

Subscriber's Employer: _____

Client ID # _____

Group/Plan # _____

Authorization # _____

Secondary:

Name/Type: _____

Subscriber Name _____

Subscriber's Employer: _____

Client ID # _____

Group/Plan # _____

Authorization # _____

I authorize the release of information that may be required by my health insurance company and is necessary for treatment plan updates and to submit claims and pursue claim payments. I understand that Virginia D Reiber Ph.D utilizes a billing person who may interact on their behalf with my insurance company. This billing person is also bound by state and federal rules of confidentiality. **I understand that I am financially responsible for all charges regardless of my insurance coverage.**

Patient or Adult Guardian (if minor)

Date

----- FOR OFFICE USE ONLY -----

Date of First Appointment: _____

DX: _____