HARBOR HEALTH AND WELLNESS LLC

Patient Registration Form

REFERRAL INFORMATION: Date Called: ________________ Therapist: ____________________________
Chief Complaint/ Issues: ____
Referral Source: ____________________________ Appointment Date: ___________ Time: _________

PATIENT INFORMATION: First Name: __________________ Last Name: ______________________ MI: ____

D.O.B: ____________ Age: ____ Gender: ☐ M ☐ F ☐ Other_______________ SS#: __________________

Home Address: ______________________________ City: ______________________ State: __________

Zip: _______________-__________ Email: ____

Home Phone: __________________ Cell Phone: _________________ Work Phone: _________________
✶Leave Message? ☐ Yes ☐ No ✶Leave Message? ☐ Yes ☐ No ✶Leave Message? ☐ Yes ☐ No
How would you like appointment reminders? **(check all that apply)** ☐ Home ☐ Cell ☐ Text ☐ Email

IF UNDER 18 YEARS OLD:

Mother's Full Name: ____ D.O.B: _________________

Full Address **(If Different)**: ____

Home Phone: _________________ Cell Phone: _________________ Email: _________________________

Employer: ____ Phone: ___________________________
Where can we leave a message for mom? **(check all that apply)** ☐ Home ☐ Cell ☐ Text ☐ Work ☐ Email

Father's Name: ____ D.O.B: _________________

Address **(If Different)**: ____

Home Phone: _________________ Cell Phone: _________________ Email: _________________________

Employer: ____ Phone: ___________________________
Where can we leave a message for dad? **(check all that apply)** ☐ Home ☐ Cell ☐ Text ☐ Work ☐ Email

INSURANCE INFORMATION: Responsible Party/ Insured: ____

D.O.B: _____________ SS#: ____________________ Relationship To Patient: ________________________

Address **(If Different from above)**: ____

Employer: ____ Phone: ____________________

Name of Insurance Co: _______________________________________ Phone: ____________________

Address for Claims: ____ Effective Date: ___________

Issuer/Policy #: _____________________ Member ID: ____________________ Group #: _____________

SECONDARY INSURANCE: Responsible Party/ Insured: ____

D.O.B: _____________ SS#: ____________________ Relationship To Patient: ________________________

Address **(If Different from above)**: ____

Employer: ____ Phone: ____________________

Name of Insurance Co: _______________________________________ Phone: ____________________

Address for Claims: ____ Effective Date: ___________

Issuer/Policy #: _____________________ Member ID: ____________________ Group #: _____________

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BENEFIT VERIFICATION: Date: __________ Spoke With: __________________________ Effective Date: ___________

IN NETWORK: Deductible: ________________ Deductible Remaining: ________________ Co-pay: ______________

Co–Insurance %: ___________ Max $ Per Visit: __________ Max Annual Visit: __________ Max $ Per Year: __________

Out of Pocket Max: _____________ Lifetime Max: _____________ **Coverage Year Begins:** ____________

OUT OF NETWORK: Deductible: _______________ Deductible Remaining: _______________ Co-pay: _____________

Co–Insurance %: ___________ Max $ Per Visit: __________ Max Annual Visit: __________ Max $ Per Year: __________

Out of Pocket Max: _____________ Lifetime Max: _____________

MANAGED CARE CONTACT (EAP/ ERC): Agency/Insurance Plan: ____

Contact Person: ____ Phone: _______________________________

Authorization #: ____________________________ # of Sessions: _______ From: ________ Through _______

Approved Sessions: ______________________

FINANCIAL RESPONSIBILITY COMMITMENT:

Fees for services are your responsibility. As a service to you, we will contact your insurance for verification of your benefits. However, it is important that you also verify your benefits. We request you pay deductibles, co-pays, and outstanding balances at the time of service. Monthly payment arrangements must be set up in advance. We urge you to inform us if you have temporary financial problems to help us avoid sending you unnecessarily to collections. We prefer to work out an arrangement directly with you.

I, the undersigned, certify that I have (or my dependent has) insurance coverage with ____ insurance and assign directly to Harbor Health & Wellness LLC all insurance benefits, if any, otherwise payable to me for services rendered.

I understand I am financially responsible for all charges whether or not paid by insurance.
I hereby authorize the provider to release all information necessary to secure payment of benefits.
I authorize the use of this signature on all insurance submissions and personal payments.

Signature: ____ Date: _____________________