PSYCHOLOGICAL ASSOCIATES OF WILLIAMSBURG
REGISTRATION INFORMATION
(Please print)

Home Phone ___________________________

Date ____ / ____ / ________

Cell Phone ___________________________

Client Name ____ **SS#** _____ / ____ / ______
(Last) (First) (Initial)

Physical / Mailing Address of Client ____
(Circle One)

City _______________________________ **State** _________ **Zip** __________

Gender __ M __ F **Date of Birth** ____ / ____ / ______ **Marital Status** ______________

___ **Employed** ___ **Student** **Name of Employer / School** ____

Occupation ____ **Work Phone** ______________________________

Employer's Address ___________________________________ ____

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Name of Individual Responsible For Bill __________________________________ **Relationship** ___________
(Last) (First) (Initial)

Address (if different from above) ____

Home Phone ___________________ **Work Phone** __________________ **Cell Phone** __________________

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Current Medical Problems ____

Current Medications ____

List Any Drug Allergies ____

Primary Care Physician ______________________________________ **Phone Number** ____________________

Please list names/ages of children/siblings if applicable ____

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Services Covered by Medical Insurance? ___ **Yes** ___ **No**

Name of Insurance Company ____________________________

SERVICES MUST HAVE BEEN CONFIRMED / PREAUTHORIZED PRIOR TO INITIAL VISIT

Insurance Sponsor _______________________________________ **Employer** ____________________________
(Last) (First) (Initial)

Sponsor's Date of Birth ____ / ____ / _______ **Relationship to Client** _______________ **SS#** ____ / ___ / ____

Sponsor's Home Address if Different from Above ____

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1. **Do we have your permission to call and / or leave phone messages at your**
   home phone # ______________________________________ ___ Yes ___ No
   work phone # ______________________________________ ___ Yes ___ No
   cell phone # ______________________________________ ___ Yes ___ No

   If the answer to all of the above is "NO", then how may we contact you? _________________
   ____

2. **Please designate the address to which we have your permission to mail correspondence.**

   ____

3. **In case of an emergency, whom should we contact?**
   Name ____ Relationship ____________________
   Phone # _____________________________________ home / work / cell ?
   Phone # _____________________________________ home / work / cell ?

Who may we thank for referring you? ____

RELEASE & ASSIGNMENT OF PAYMENT

My signature verifies that the information that I have given is correct to the best of my knowledge.
I understand that it will be held in strictest confidence, and that it is my responsibility to inform this office of any changes in a timely fashion.
I understand that I am financially responsible for all charges whether paid by my insurance carrier or not. I hereby authorize Psychological Associates of Williamsburg to release any information necessary to secure payment of benefits by my insurance company.
I authorize the use of this signature on all insurance claim submissions whether manual or electronic.
I agree to pay all copays, deductible amounts, etc. at the time of service as required by my insurance company.
I agree to abide by the cancellation policy of "a minimum of 24 hours prior to an appointment" and to be responsible for any late cancellation or no show fees incurred for not having adhered to the stated policy.
I agree to be responsible for any delinquent fees incurred in the collection of any monies due.

Signature ____ Date _____ / _____ / ________