



ACCESS REGISTRATION FORM

SS# _____ Date _____
Name: Last _____ First: _____ Middle: _____
Address: _____ City: _____ State: _____ Zip Code: _____
County: _____ Home Phone (____) _____ Work Phone (____) _____
Birth Date: _____ Age: _____ Sex: _____ Race: _____ Ethnicity: _____ Highest Grade completed: _____
Dependents: Self ___ Spouse ___ Children ___ Others ___ (specify: _____)

Guardian (if applicable):

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone (____) _____ Cell Phone (____) _____ Relationship to Client: _____

Reason for Seeking Service:

Who referred you to or where did you hear about our Services? _____

Are you now, or have you ever been a member of the US Armed forces? _____

Emergency contact: Last Name: _____ First Name: _____ Middle Name: _____
Home Phone (____) _____ Cell Phone (____) _____ Relationship: _____

Employment status: Employer's Name: _____ Employer's Address: _____
Spouse's Employer: _____ Spouse's Work Telephone: _____

Responsible party (if different from client):

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone (____) _____ Client's/Guarantor's Drivers License # and State: _____

Insurance Company Name _____ Phone # _____

Subscriber's: Name _____ SSN _____ DOB _____

Subscriber Gender: Male ___ Female ___

Client Relationship to Subscriber: Spouse ___ Bio Child ___ Stepchild ___ Grandparent ___ Other _____

Subscriber # _____ Group # _____ Effective Date _____

Subscriber's Employer _____ Address _____

Medicare Type: A ___ B ___ Medicare Number _____ Effective Date _____

Tricare Prime ___ Standard ___ Effective Date _____ SSN _____ DOB _____

Sponsor's: Name _____ Sponsor's Gender: Male ___ Female ___

Branch of Service _____ Grade / Rank _____ Active ___ Retired ___ Deceased ___

Client Relationship to Sponsor: Spouse ___ Bio Child ___ Stepchild ___ Grandparent ___ Other ___

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Appointment and fee contract

1. ___ All services are payable at the time the services are rendered including insurance deductible and estimated co-payments. On-going services may be temporarily terminated if my account becomes more than two (2) appointments or payments in arrears.
2. ___ My insurance deductible amount is \$_____. My insurance company reports that I shall have to pay \$_____ to meet my deductible. After meeting my deductible, my co-pay amount will be \$_____.
3. ___ Any scheduled appointment must be cancelled at least 24 hours in advance or I will be charged a no show fee for that appointment unless prohibited by insurance regulations.

Client's Name [**Please Print**]: _____

Signature of Client or Parent / Guardian

Date

Witness (Provider)

Date

PSYCHIATRY CLIENTS ONLY:

Preferred Pharmacy: _____

Phone Number: _____

Address: _____
