Print Form

PATIENT INFORMATION

TODAY'S DATE

NAME _____ SS# (optional) _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP CODE _____ WORK PHONE _____

BIRTHDATE _____ AGE _____ SEX ◯ M ◯ F ◯ T CELL PHONE _____

MARITAL STATUS ◯ S ◯ M ◯ D ◯ W ◯ SEP EMAIL ADDRESS _____

Preferred phone Number to use for appointment reminder or schedule change notification: _____

EMPLOYER _____ OCCUPATION _____

SPOUSE NAME _____ SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

◆ COMPLETE IF THE PATIENT IS UNDER AGE 18 OR A STUDENT *or* IF PARENT(S) RESPONSIBLE ◆:

FATHER'S NAME _____ EMPLOYER _____

FTR's ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE: H# _____ W# _____ C# _____

Use as Emergency Contact? ◯ YES ◯ NO If so, preferred number to call: _____

MOTHER'S NAME _____ EMPLOYER _____

MTR's ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE: H# _____ W# _____ C# _____

Use as Emergency Contact? ◯ YES ◯ NO If so, preferred number to call: _____

Parent's Marital Status (check one) ☐ **Married/Co-habitating** ☐ **Divorced** ☐ **Separated** ☐ **Never Married**

PARENT WITH PRIMARY PHYSICAL CUSTODY _____

HOW DID YOU HEAR ABOUT US?

☐ REFERRED BY DR. _____ ☐ OTHER _____

FAMILY DOCTOR _____ **PHONE** _____

ADDRESS _____

INSURANCE INFORMATION - *THIS INFORMATION IS NECESSARY FOR US TO BILL YOUR INSURANCE COMPANY*

PRIMARY INSURANCE: _____ ID# _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

SUBSCRIBER'S ADDRESS (If different than above) _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE: _____ ID# _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH _____

SUBSCRIBER'S ADDRESS (If different than above) _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

** With the exception of MEDICARE, ***Riegler Shienvold & Associates*** bills neither secondary insurance nor those companies with whom we do not participate. You will be provided an invoice for services that contains all information necessary for you to bill your claims.

(Next page, please)

AUTHORIZATION AND RELEASE

AUTHORIZATION FOR TREATMENT: I authorize treatment of the patient named above and agree to pay all fees and charges not paid by my insurance company for such treatment.

Signature	Relationship to Patient	Date

AUTHORIZATION TO CONFIRM OR CORRESPOND (Optional): I hereby authorize Riegler, Shienvold and Associates to contact me at home / work to confirm my appointments and to send periodic correspondences to my home.

Signature	Relationship to Patient	Date

THE FOLLOWING ASSIGNMENT AND RELEASE MUST BE COMPLETED AND SIGNED IF YOU WOULD LIKE US TO BILL YOUR INSURANCE — INCLUDING HMO'S

ASSIGNMENT AND RELEASE: I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and/or their designated mental health managed care company and assign directly to Riegler, Shienvold and Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I hereby authorize Riegler, Shienvold and Associates to release all information necessary to obtain authorizations and/or secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature	Relationship to Patient	Date