

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS			
CITY, STATE		ZIP	HOME PHONE		CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____	
PATIENT EMPLOYER NAME					
INSURED/RESPONSIBLE PARTY INFORMATION			RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER	
INSURANCE INFORMATION					
PRIMARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
SECONDARY INSURANCE NAME		ADDRESS (STREET - CITY - STATE - ZIP)			PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER		EMPLOYER PHONE	
PRIMARY DOCTOR/FAMILY DOCTOR			REFERRING DOCTOR		
IN CASE OF EMERGENCY CONTACT			RELATIONSHIP	PHONE NUMBER	

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Monique R. Lowe PhD, LLC and I am financially responsible for non-covered services. I also authorize the Monique R. Lowe PhD, LLC to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE
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Authorization to release health information to:

Name(s)		ADDRESS		
CITY, STATE		ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: _____ TO: _____		AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) <input type="checkbox"/> NEVER DATE: _____		
Release the following information:				
<input type="checkbox"/> Other	<input type="checkbox"/> Medical	<input type="checkbox"/> Educational Evaluations/Reports	<input type="checkbox"/> Psychotherapy	<input type="checkbox"/> Employment

RELEASE OF INFORMATION

I understand that:

- once "this office" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this office as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to Monique R. Lowe PhD, LLC.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	