Robert E Parker PhD
A Psychological Corporation
471 E. Tahquitz Canyon Way #219
Palm Springs, CA 92262
206-824-7275

Office Use Only

Diagnosis Code _____

Intake Date _____

CLIENT REGISTRATION

This registration/insurance form is part of your clinical record. The information you provide is held to the same standards of confidentiality as your therapy. Please fill out this form completely, however you may leave blank any questions you prefer not to answer.

Name _____ DOB _____ Gender_____

HomeAddress _____

City _____ State _____ Zip _____

Mailing Address (if different) **_____**

Home Phone _____ May I leave a Message? Yes ___ No___

Cell/Other Phone _____ May I leave a Message? Yes ___ No ___

EmploymentStatus_____
Marital Status _____ Spouse/PartnerName_____

Name of Person to contact in emergency:
_____

Relationship to you _____Phone_____

Physician: Name_____ Phone _____

PhysicianAddress_____

The next page asks you to provide insurance information. Copies of primary and secondary insurance cards are required in order for me to bill insurance properly. If you provide your insurance cards at the time of completing this registration form, simply list the names of your primary (and any secondary) insurance(s), and then sign and date the bottom of the page.

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PAYMENT INFORMATION

****A Copy of an Insurance card(s) provide all needed information****

Signature & Date are needed at bottom

For <u>Private Pay</u> Only (please initial) _____

Primary Insurance: _____

Address: _____

ID #: _____ **Group #**: _____

Subscriber: _____ **Client Relation to Subscriber**: _____
Subscriber's Address: _____

Last 4 of Subscriber SS#: ***-**- _____ **Subscriber's Birthdate**: _____

Employer:_____

Other Insurance: _____

Subscriber Name: _____

Subscriber Birthdate: _____ Ins. ID#: _____ Group #: _____

I understand that I am responsible for my bill, and that my insurance coverage is a contract between myself and a third party. In cases where Dr. Parker bills my insurance, I authorize that insurance benefits be paid directly to Dr. Parker. I also authorize Dr. Parker to release any information required to process insurance claims. I understand that I am responsible for deductibles, co-payments, co-insurance, payments for non-covered services, and/or other balances due.

<u>Medicare Authorization</u>*: I request that payment under the Medicare Insurance program be made either to me or to Dr. Parker on any bills for services furnished me by that physician during the period _____ to December 31, _____. I also give my permission for release of necessary medical information to any carrier, listed on the claim for purposes of processing this or any related Medicare claim.*

My signature below authorizes Dr. Parker to submit bills and all necessary information to my insurance company for the purpose of insurance reimbursement. My signature remains in effect until treatment is completed, or until I notify Dr. Parker in writing that my authorization to bill my insurance company is withdrawn.

_____ _____ _____
Client/Responsible Party Signature Relationship Date