v. 20200324

One Oak Plaza, Suite 208, Asheville, NC 28801
Phone: 828-575-9760 Fax: 828-575-9761
https://www.acaps-nc.org

Patient Registration Form

Name/Relationship of Person Completing This Form:

PATIENT INFORMATION: (Please use full **legal** name, no nicknames)

Last Name: ______________________ First Name: ______________________ Middle Initial: _______

Address: ____

City: ______________________ State: ______________________ Zip: ______________

Home Phone #: (_____)______________________ Social Security #: ______________________

Date of Birth: ______________ Age: ________ Marital Status: ______________________

Biological Sex: M___ F___ Other ___ Gender Identity ______________________

Employer Name and Address: ____

Work Ph#: (____) ______________ Preferred E-mail Address: ______________________

Cell Ph# : (____) ______________ Home Ph# : (____) ______________Can we leave voice/text messages ? Yes / No

Emergency Contact Name: ______________________ Emergency Phone#: (____) ______________

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full **legal** name, no nicknames)

Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other ______________

Last Name: ______________________ First Name: ______________________ Middle Initial: _________

Address: ____

City: ______________________ State: ______________________ Zip: ______________

Home Phone #: (____) ______________ Cell Ph# (____) ______________ Social Security #: ______________

Date of Birth: ______________ Age: ____________ Biological Sex: M___ F___ Other ___

INSURANCE INFORMATION: (Please provide your insurance ID cards for photocopying)

IF SOMEONE OTHER THAN THE PATIENT IS THE INSURED PARTY, GUARANTOR INFORMATION MUST BE COMPLETED IN FULL

PRIMARY INSURANCE:

Plan Name: ______________________ Insured's Name: ______________________

Insured's Social Security #: ______________________ Insured's Date of Birth: ______________________

Policy/ID #: ______________________ Group #: ______________________ Eff Date: ______________

Claims Address & Phone: ____

SECONDARY INSURANCE:

Plan Name: ______________________ Insured's Name: ______________________

Insured's Social Security #: ______________________ Insured's Date of Birth: ______________________

Policy/ID #: ______________________ Group #: ______________________ Eff Date: ______________

Claims Address & Phone: ____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider/ACAPS. I understand that I am financially responsible for any balance. I also authorize Appalachian Counseling and Psychological Services, Inc or insurance company to release any information required to process my claim.

Patient/Guardian Signature: ______________________________ Today's Date: ______________