



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: _____