v. 20200324

Phone: 828-575-9760 Fax: 828-575-9761
www.apppsych.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: _____________