REGISTRATION FORM MASON ASSOCIATES LLC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Full Legal Name:_____ Preferred Name: _____

Address:_____

City/State/Zip:_____

Phone:_____ Email:_____

What type of appointment reminder do you prefer (circle one): text email phone call

Date of Birth: _____/_____/_____

Marital Status: Single ____ Separated ____ Divorced____ Married ____ Widowed____ Other:_____

Primary reason for coming: _____

Primary Care Provider/Psychiatrist Name:_____

Current Medications (specify what for): _____

_____

Past/Present Counseling or Therapy:_____

In Case of Emergency Please Contact:_____ Phone:_____

Insurance Information

Primary Insurance Company:_____ Phone: _____

Policy/ID # _____ Group/Plan # _____

Secondary Insurance Company:_____ Phone: _____

Policy/ID # _____ Group/Plan # _____

Policy Holder Information: (if the patient is not the policy holder)

Name (Last, First, Middle): _____

Client Relationship to Insured: Self_____ Partner/Spouse _____ Child_____ Other: _____

Address: _____City: _____State: _____ DOB: _____

Authorization:

I hereby authorize Mason Associates LLC to furnish the insured's insurance company information, which said insurance company, may request concerning my present circumstances. I further authorized Mason Associates LLC to release diagnostic information relative to my treatment, to a laboratory or hospital of my choice, for billing purposes only. I hereby assign Mason Associates LLC all money to which I am entitled for expenses relating to the services performed from time to time, but not to exceed my indebtedness to Mason Associates LLC. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Mason Associates LLC for charges not covered by this assignment. I further authorize photocopies to be made of this authorization and assignment for attachment to any insurance form and authorize the insurance company to accept the photocopy. The authorization shall continue and be in force and effect until revoked in writing by me.

_____ _____

Signature Date

_____

Printed Name