CAROLYN G. MAURER, PHD, LPC, LMFT, PC
PATIENT REGISTRATION

Patient Name____ SS#_____________________________

Parent Name (if patient is a dependent) ____ SS#_____________________________

Street Address ____ City_________________________ State_____ Zip________

Home Phone ___________________________ Work Phone __________________________ Cell Phone _______________________

Date of Birth _______________________ Email (patient / parent) ____

Sex: M__ F__ Marital Status: S__ M__ W__ Sep__ D__ Driver's Lic #: ____________________________ State _____

Employer _______________________________ Address ___________________________ City _____________ State ___ Zip _____

Patient Status: Employed __ Full-time Student __ Part-time Student __ School ____

Emergency contact _________________________________ Relationship ______________________ Phone ______________________

Referred by ______________________________ Primary Care Physician ______________________ Phone ______________________

PRIMARY INSURED (IF NOT PATIENT)

Name____ SS#______________________________

Address (if different from patient) ____ City ______________ State ____ Zip _______

Home Phone __________________________ Work Phone _____________________________ Date of Birth _____________________

Sex: M__ F__ Marital Status: S__ M__ W__ Sep__ D__ Patient Relationship to Insured: self__ spouse__ child__ other__

Employer _______________________________ Address ___________________________ City _____________ State ___ Zip _____

INSURANCE PLAN INFORMATION

Primary Insurance Company Name ____

Address ____ City_________________________ State_____ Zip________

ID# ____________________________________ Group/Policy# _________________________ Authorization # ____________________

Medicare # ____ Medicaid # ____

Secondary Insurance Company Name ____
If none, initial here ___________

Name of Insured ____ ID # ____________________ Group/Policy # _________________

ASSIGNMENT OF BENEFITS

I hereby authorize Carolyn G. Maurer, PhD, to apply for benefits on my behalf for covered services rendered by her order. I request that payment from my insurance company be made directly to Dr. Maurer. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or my insurance company at any time in writing. The HIPAA consent form in my file serves as my consent to release any medical information necessary to process this claim.

Date ______________________________ Signature ____