## WHOLE MENTAL WELLNESS

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | Primary Care Provider: | | | | | | | | | | | | | | | | |
| PCP Address: | | | | | | | | | | | | | | | | | | PCP Phone # : | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | First: | | | | | | | | Middle: | | ❑ Mr.  ❑ Mrs. | | | | | ❑ Miss  ❑ Ms. | | | | | Marital status (circle one) | | | | | | | |
|  | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | |
| Is this your legal name? | | | | If not, what is your legal name? | | | | | | | | (Former name): | | | | | | | | | | | | | Birth date: | | | | | Age: | Sex: | | | |
| ❑ Yes | | ❑ No | |  | | | | | | | |  | | | | | | | | | | | | | / / | | | | |  | ❑ M | | ❑ F | |
| Social Security no.: | | | | | | | | | | | | | Home Phone #: | | | | | | | | | | | | | | | | | | | | |  |
| Cell Phone #: | | | | | | | | | | | | | Other Phone #: | | | | | | | | | | | | | | | | | | | | |  |
| Street Address: | | | | | | | | | | | | | P.O. box: | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |  |
| City: | | | | | | | | State: | | | | | | | | | | | ZIP Code: | | | | | | | | | | | | | | |  |
|  | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | |  |
| Occupation: | | | | | | | | Employer: | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | |
| Current Therapist: | | | | | | | | Therapist Address: | | | | | | | | | | | | | | | | Therapist Phone #: | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | ❑ Dr. | |  | | | | | | | | | | | | ❑ Insurance Plan | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | ❑ Close to home/work | | | | | | ❑ Yellow Pages | | | | | | | | ❑ Other | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PHARMACY**: ADDRESS: PHONE #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INSURANCE COMPANY NAME/TYPE**:    (While we ***do not accept*** insurance, it is helpful for our Prescribers to know what coverage type you have so they can check, ahead of time, for the “Preferred Medication” of your Insurer. This will save phone calls and time between Provider & Pharmacy, so you can get medications filled in timely manner, without unnecessary delays) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | Relationship to patient: | | | | | | | | | | Home phone no.: | | | | | | | | | Work phone no.: | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | ( ) | | | | | | | | | ( ) | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize WHOLE MENTAL WELLNESS or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | |  | | Date | | | | | | | | | | |  |
| **EMAIL ADDRESS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PAYMENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| We are a fee for service practice. We do not accept insurance. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| we will provide you with a superbill/receipt at time of payment for you to submit to your insurance company. Most insurance companies will reimburse at an “out of network” PERCENTAGE. you should call and check what your coverage is to ensure you are comfortable and able to pay up front and do this reimbursement. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature acknowledging Payment  Agreement: | | | | | |  | | |  | | Date: | | | | | | | | | | | | | | | | | | | | | | | |
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