

Psychological Health-Roanoke-MINOR REGISTRATION

Date: _____ Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Patient: _____
 First Middle Last

Address _____
 Street and PO Box

 City State Zip Code

Age _____ Birth Date _____ Social Security # _____

Responsible Party _____ DOB: _____
Social Security # _____ Relation to patient: _____
Business and Address _____
Occupation: _____ Business Phone _____

If custody is shared both responsible parties need to be listed:

Responsible Party _____ DOB: _____
Social Security # _____ Relation to patient: _____
Business and Address _____
Occupation: _____ Business Phone _____

Do you have Medical Insurance? **Yes, please provide a copy to the receptionist at time of check-in.**
If No, then payment is due in full date of service.

REQUIRED INFORMATION:

In case of emergency, who should be notified? _____ Phone: _____
Relation to patient: _____

I authorize treatment deemed necessary by the health care providers of Psychological Health- Roanoke.

A law enacted in Virginia in 1989, authorizes health care providers to test their patients for HIV antibodies and other blood borne pathogens when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV) and other blood borne pathogens. Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies and other blood borne pathogens and the testing would be explained. You could ask any questions you might have at that time.

I authorize Psychological Health-Roanoke to release to my health plan any and all information which it deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment of all insurance benefits to Psychological Health- Roanoke for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Psychological Health-Roanoke for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicare or Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due within thirty days of receipt of a statement.

In consideration of the services rendered and to be rendered pursuant to my request for medical services from Psychological Health- Roanoke, I hereby waive any right to a jury trial should Psychological Health-Roanoke have to file suit to collect my account.

METHODS OF PAYMENT:

Our office accepts the following payment methods:

Cash, Personal Check and Credit Cards.

For returned checks we assess a \$50.00 NSF charge, and report to the local Commonwealth attorney's office checks that are not paid within 2 weeks of being returned to our office.

If fees are not paid, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The parties agree that all claims, disputes and other matters of action shall be brought within and decided in the Commonwealth of Virginia.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THIS INFORMATION.

Responsible Party for Minor

Date