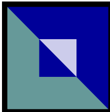

David Mabry, MA, LPC

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PATIENT REGISTRATION
(PLEASE PRINT)

Today's Date:_________________

Patients full name:_______________________________________SS#:_________________________

Home Address_____________________________City:________________State:__________Zip:____________

Home Phone:_______________________________

Cell Phone:________________________________Sex:______Age:_______Date of birth:___________________

Patient or Parent/Guardian's employer:________________________________Phone #:______________________

If Student, Grade:______School:____

Family Physician:_________________________Physician's phone #:_____________Referred by:_____________

Person to contact in an emergency:_________________________________Phone #:________________________

INSURED/RESPONSIBLE PERSONS INFORMATION

Please complete this section regardless of insurance coverage

Full Name of Responsible person___________________________Birthday:____________Relationship:________

Home Address:(Same as above ___)__________________________City:___________State:_____Zip:________

Employer:____Phone#:_________________________

Insured's/Responsible person SS#________________________Driver's License #:________________State_____

Full Name of Spouse____

Spouse's Employer Address:_______________________________________Phone #:_______________________

Insured's Primary Ins. Co.___________________________ID#:__________________Group#:_______________

Secondary Ins. Co._________________________________ID#:__________________Group#:_______________

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form for all my insurance submissions.
2. I authorize at the release of information to insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Signature:____Date:_______________________

- It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time service is provided.
- There will be a $25.00 service charge on all returned checks.
- In event that your account goes to collections, there will be a 20% collection fee added to your balance.
- There is a 24 hour cancellation policy. You must cancel your appointment 24 hours in advance, between the hours of 8am and 8pm Monday through Friday. If not, then it is counted as a "no show" appointment. After 3 "no show" appointments, I reserve the right to terminate.

Signature:____Date:_________________________