Hazel Approach Psych Services

1214 Park St, Suite 201B, Stoughton, MA 02072

PATIENT REGISTRATION & INFORMATION

Legal Name: _____ **Preferred Name**: _____

Address: _____

City: _____ State: _____ Zip: _____ **DOB**: ___/___/_____ **Age**: ____

Living Arrangement: ☐ Self/Alone ☐ With Family/Other ☐ Temporary Housing (ex. Shelter)
☐ Group/Residential Placement ☐ Foster Home ☐ Other _____

Preferred Method of Contact (choose one): ☐ Cell Phone ☐ Home Phone ☐ Email ☐ Work Phone

Phone Number: Ok to Leave Message? ☐ Yes ☐ No

Email Address: _____

Gender: ☐ Male ☐ Female ☐ Nonbinary ☐ Transgender Trans-female ☐ other (please state):_____

Relationship Status ☐ single ☐ married/domestic-partnership ☐ divorced ☐ widowed

Emergency Contact (Not applicable for minors): _____

Relationship _____ Phone Number _____

Minors Only: (under age 18 years old)

Custody Arrangement:

☐ **Parents Married**: shared legal/physical

☐ **Parents Divorced or Never married**:

☐ sole legal custody ☐ shared legal

☐ sole physical custody ☐ shared physical custody

Parent: _____ Parent: _____
Telephone/Email: _____ Telephone/Email: _____
Address:_____ Address:_____
_____ _____

☐ I am currently involved with the Department of Children and Families

☐ I am currently involved in Department of Mental Health or Department of Developmental Services

☐ I am currently involved with the Juvenile Court and/or the Department of Youth Services

☐ I am currently involved in a legal matter (civil or criminal)

☐ I might request your involvement as a witness. Attorney: _____

Method of Payment for Services

☐ Insurance ☐ Self-pay ☐ Other Arrangement _____

Insurance Policy Subscriber or ***Person Responsible for Billing*** _____

Insurance Company: _____ Plan: _____

Group #: _____ Co-Pay:_____

Member ID Number: _____ Provider's Phone # _____

Subscriber's DOB: ___/___/_____ Relationship to the patient: _____

Subscriber's Address (if different than patients) _____

City: _____State: _____ Zip: _____

Subscriber's Employer _____

☐ Unemployed

☐ Full-time Student: School Attending _____

Please bring a copy of your insurance card to your intake appointment.

DISCLAIMER: RESPONSIBILITY FOR ALL FEES CHARGED

By signing this patient registration form, you acknowledge and agree that you are responsible for all fees charged by the healthcare provider, regardless of any insurance coverage you may have. It is important to understand that insurance coverage, benefits, and reimbursements are determined by your insurance provider's policies and agreements, and they may not cover the full extent of the services rendered.

You understand that it is your responsibility to verify your insurance coverage, including any deductibles, co-payments, and out-of-pocket expenses that may apply. In the event that your insurance provider denies or partially covers a claim, you agree to pay any remaining balance directly to the healthcare provider.

Furthermore, you acknowledge that you will be responsible for any fees incurred due to missed appointments, late cancellations, or failure to provide accurate and up-to-date insurance information. These charges may not be covered by insurance and will be your sole responsibility.

It is important to review your insurance policy, understand its limitations, and communicate any changes in coverage to the healthcare provider promptly. By signing this form, you accept full financial responsibility for all services rendered by the healthcare provider and agree to make timely payments for any outstanding balances.

Please note that this disclaimer does not relieve the healthcare provider of their obligation to submit claims to your insurance provider on your behalf, or to comply with applicable laws and regulations governing billing practices.

If you have any questions regarding your financial responsibilities or need assistance understanding your insurance coverage, we encourage you to contact our office or consult with your insurance provider directly.

Signature of Responsible party _____ Date _____