

# CARY BEHAVIORAL HEALTH PC

160 N.E. MAYNARD ROAD, SUITE # 200, CARY, NC 27513

PHONE 919-466-7540 FAX 919-466-7543.

## REGISTRATION FORM

### Patient Information:

Please Print

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone(\_\_\_\_) \_\_\_\_\_ Work (Cell) Phone(\_\_\_\_) \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex : Male \_\_\_\_\_ Female \_\_\_\_\_

Date Of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employment : Full Time \_\_\_\_\_ Retired \_\_\_\_\_ Not Employed \_\_\_\_\_ Student \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone \_\_\_\_\_

### Primary Insurance Coverage:

Company \_\_\_\_\_ ID# \_\_\_\_\_

Is Pre-Certification Required? Yes \_\_\_ No \_\_\_ Certification # \_\_\_\_\_ # of visits \_\_\_\_\_  
Start Date \_\_\_\_\_ End Date \_\_\_\_\_

### Primary Policy Holder:

If patient is not the policy holder, please give name of policyholder:

Name of Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's SS#: \_\_\_\_\_ Policyholder's Date of Birth \_\_\_\_\_

### Assignment and Release

I, undersigned certify that I (or my dependant) have insurance coverage with \_\_\_\_\_ and assign directly to Cary Behavioral Health PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that I am responsible for obtaining any initial

authorizations required by my insurance carrier for each separate provider that I see. I hereby authorize the doctor/therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date