DX:

JACQUELINE TITUS, PHD
411 LAKE LANSING RD., SUITE 120A
EAST LANSING, MI 48823

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Address**:** _____ City**:** _____ Zip: _____

Phone**: ( )** _____ Work**: ( )** _____ Cell**: ( )** _____

SSN: _____ Employer: _____

Sex M F Marital Status: Single Married Divorced

Primary Care Physician: _____ Phone: _____

Responsible Party (if different from above): _____

Address**:** _____ City**:** _____ Zip: _____

Phone**: ( )** _____ Work**: ( )** _____ Cell**: ( )** _____

Primary Insurance Information (please present insurance card)

Insurance: _____

Policy # _____ Group # _____

Policy Holder's Name: _____SSN _____

Insured's DOB: _____ Employer: _____

Secondary Insurance Information (please present insurance card)

Insurance: _____

Policy # _____ Group # _____

Policy Holder's Name: _____SSN _____

Insured's DOB: _____ Employer: _____

AUTHORIZATION TO BILL INSURANCE

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized Therapist/billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Therapist/billing company. If I have Medicare insurance, I authorize Therapist/billing company to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Doctor/Therapist/billing company by written request.

Signature: _____ Date _____