Metro West Center For Well Being Patient Registration Form

Name:_____ Age:_____
Referred by_____ Date of Birth:_____
Home Phone:_____ Marital Status: S M W D Pt
cell #: _____

Text reminders OK? Yes or No

Pt email_____

Parent cell:_____Text reminders OK? Y N Parent email _____ Home Address: _____ Apt # ____ PO Box : _____ City:_____ State: _____ Zip _____ Primary Language Spoken: _____ Religion: _____ Preferred Pharmacy: _____ Pharmacy phone: _____
Employer/School:_____
Phone:_____ Primary Care Doctor: _____
PCP Phone:_____ PCP Fax:_____
Authorization to contact PCP: Yes or No

In Case of Emergency, please contact:

Name:_____
Phone:_____ Relationship:_____ Address: _____

If patient is a Minor, please complete:

Parent Name:_____ Daytime phone: _____

Parent Name:_____ Daytime phone: _____

Insurance Info:

Primary Insurance: _____ ID#: _____
Subscriber:_____ Subscriber birthdate:_____ Relationship to Insured: _____ Secondary Insurance: _____ ID#: _____
Subscriber:_____ Subscriber birthdate:_____ Relationship to Insured: _____

Guarantee of Payment: I understand that I am directly responsible for payment to the MetroWest Center for Well Being, LLC for all medical services rendered to me. I understand that all bills are payable and due at the time services are rendered, unless other arrangements have been made. I authorize payments to be made directly to this office.

Authorization to release Information: I hereby authorize the MetroWest Center for Well Being to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claims.

Assignment of Benefits: If this office files insurance claims on my behalf, I authorize direct payment of any benefits to the MetroWest Center for Well Being for mental health services received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by my insurance including difference in payments when no contract exists between the insurance company and MetroWest Center for Well Being. I permit a copy of this authorization to be used in place of the original.

TELEMEDICINE Authorization: The benefits and risks of participating in visits via telemedicine have been discussed with me and I have consented to using telemedicine as needed.

Signature: _____ **Date**:_____ Patient or Parent if minor