SP ASSOCIATES

Patient Registration Form

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

SSN:_____ DOB:_____ Gender:_____ AKA:_____

Mailing Address:_____ City/State/Zip:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Preferred Phone for Messages:_____ Email:_____

Race:_____ Ethnicity:_____ Language:_____ Marital Status:_____

Employment:_____ Driver's License:_____

Primary Doctor:_____ Phone #_____

Referring Doctor:_____ Phone #_____

Pharmacy:_____ City:_____ Phone #_____

Responsible Party (Bill To)

First Name:_____ Last Name:_____

DOB:_____ SSN:_____ Gender:_____

Mailing Address:_____ City/State/Zip:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Employment:_____

Relationship to Patient:_____

Emergency Contact

First Name:_____ Last Name:_____

Phone (H) #_____ Phone (W) #_____ Cell #_____

Relationship to Patient:_____

SP ASSOCIATES

Patient Name:

Primary Insurance **None:** ☐

Insurance Name:_____ ID:_____

Group No:_____ Group Name/Employer:_____

Insured Name:_____

Insured Address:_____ City/State/Zip:_____

Insured Relationship to Patient:_____ DOB:_____ SSN:_____

Secondary Insurance

Insurance Name:_____ ID:_____

Group No:_____ Group Name/Employer:_____

Insured Name:_____

Insured Address:_____ City/State/Zip:_____

Insured Relationship to Patient:_____ DOB:_____ SSN:_____

Statesboro Psychiatric Associates (SPA) does not participate with Medicare (or its commercial products), Tricare or Medicaid. I understand that if covered by any of these entities that I must sign a waiver in order to receive treatment at SPA. I understand that the waiver states that I may not file claims with Medicare, Tricare or Medicaid for services rendered by SPA, and that I am fully responsible for payment of these services. I also understand that neither I nor SPA will file with insurance that is secondary to Medicare, and that by signing the waiver I am fully responsible for office visits.

I understand that it is my responsibility to alert Statesboro Psychiatric Associates to any and all changes in my insurance coverage, and that failure to provide these updates in a timely fashion may result in denial of claims by my new insurance company, and that I will be fully responsible for payment of these services.

I understand that unpaid balances are cause for dismissal from the practice, and that in the event that my account is forwarded to an outside agency for collection, a charge of 33% will be added to the outstanding balance to cover this cost.

Signature of Patient/Responsible Party:_____ **Date:**_____
*Digital Signature

SP ASSOCIATES

Credit Card Authorization Form

Name of Patient: _____ Date: _____

Full name on Credit Card: _____

American Express: ◯ Discover: ◯ Master Card: ◯ Visa: ◯

Card Number: _____

Expiration Date on Card: _____ CVV Code: _____

Payee Phone Number: _____

Billing Address on Card: _____

_____

(City) (State) (Zip)

- I give Statesboro Psychiatric Associates permission to charge the above credit card for payments due after each visit, and for any balances to include charges incurred due to appointments missed or canceled without appropriate notice.

Signature of Cardholder: _____ Date: _____

*Digital Signature

- If I have any questions about these charges, I agree to contact Statesboro Psychiatric Associates. I agree that I will not pursue a refund directly through my credit/debit card company, bank or financial institution. If any of my actions yield a charge back fro any reason, I agree to pay any and all penalty fee(s) incurred by Statesboro Psychiatric Associates. I also understand that my card information will be kept secure.

Signature of Cardholder: _____ Date: _____
*Digital Signature