Jason G. Stentoumis, PSY.D.
REGISTRATION FORM

INTAKE DATE: _____ COMPLETED BY: _____
REFERRING PHYSICIAN: _____

PATIENT NAME: _____ **DATE OF BIRTH**: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
SS#: _____ EMPLOYER: _____
PHONE: _____ WORK PHONE: _____
SEX: Female Male MARITAL STATUS: Single Married Divorced
RESPONSIBLE PARTY: _____ SS#: _____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE: _____ WORK PHONE: _____
INSURANCE #1: _____
POLICY #: _____ GROUP #: _____
POLICY HOLDER: _____ PHONE #: _____
INSURED DOB: _____ EMPLOYER: _____
INSURANCE #2: _____
POLICY #: _____ GROUP #: _____
POLICY HOLDER: _____ PHONE #: _____
INSURED DOB: _____ EMPLOYER: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)
NAME: _____ RELATIONSHIP: _____
HOME PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)
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 Jason G. Stentoumis, Psy.D. billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Jason G. Stentoumis, Psy.D.. If I have Medicare insurance, I authorize Jason G. Stentoumis, Psy.D. 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 Jason G. Stentoumis, Psy.D. by written request.

SIGNATURE _____ DATE: _____

WITNESS _____ DATE: _____