Whole Mental Wellness
Psychotherapy and Medication Management

wholementalwellness.com
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REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider:
PCP Address:	PCP Phone # :

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Social Security no.:		Home Phone #:			
Cell Phone #:		Other Phone #:			
Street Address:		P.O. box:			
City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.:			
Current Therapist:	Therapist Address:	Therapist Phone #:			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

PHARMACY: ADDRESS: PHONE #:

INSURANCE COMPANY NAME/TYPE:

(While we ***do not accept*** insurance, it is helpful for our Prescribers to know what coverage type you have so they can check, ahead of time, for the "Preferred Medication" of your Insurer. This will save phone calls and time between Provider & Pharmacy, so you can get medications filled in timely manner, without unnecessary delays)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize WHOLE MENTAL WELLNESS or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

EMAIL ADDRESS:

WE ARE A FEE FOR SERVICE PRACTICE. WE DO NOT ACCEPT INSURANCE.

WE WILL PROVIDE YOU WITH A **SUPERBILL/RECEIPT** AT TIME OF PAYMENT FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY. **MOST** INSURANCE COMPANIES WILL REIMBURSE AT AN "**OUT OF NETWORK**" PERCENTAGE. YOU SHOULD CALL AND CHECK WHAT YOUR COVERAGE IS TO ENSURE YOU ARE COMFORTABLE AND ABLE TO PAY UP FRONT AND DO THIS REIMBURSEMENT.