Client Registration Form

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Telephone #: _____ Alternate Telephone #: _____
Date of Birth: _____/_____/_____ Social Security #: _____ - _____ - _____
Marital Status: ( )Single ( )Married ( )Divorced ( ) Separated ( ) Other: _____ Age: _____
Responsible Party: _____ Relationship: _____
Occupation: _____ Work Telephone #: _____
Employer: _____ Email: _____
Client's Spouse or Parent (If a Minor): _____ Telephone #: _____
Emergency Contact: _____ Telephone #: _____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Alaycia D. Reid, Ph.D. for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize KRD Solutions, LLC (contracted billing service for Alaycia D. Reid, Ph.D.) to file a claim for these services (and to re-file as necessary to collect) with the client's insurance(s) and bill the client for any amounts for which they are responsible. I further authorize KRD Solutions, LLC to sign said claim(s) or any re-filed claim on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Name: _____ Signature: _____ Date: _____

Insurance Information

Company Name: _____ Telephone #: _____ Policy #: _____
Group #: _____ Policy Holder's Social Sec. No.: (if different from Client): _____ - ____- _____
Policy Holder (if different from Client): _____ Relationship: _____

TO BE COMPLETED BY BILLING OFFICE

Date: _____ Spoke with: _____ Circle one: In Network Out of Network
Policy Effective: _____ Co Pay Per Visit: $_____ Coinsurance Per Visit: $_____
Deductible Amount: $_____ Deductible Met: $_____ Max Visits/Max Payable Per Year: _____
Out of Pocket Max Per Year: _____ Exclusions to Policy: _____
Claims Address: _____ City: _____ St: _____ Zip: _____
Authorization #: _____ Sessions Approved: _____ Authorization Date: _____ thru _____

Notes: _____