Patient Registration

Patient Information (Please Print):

Legal Name:	Nickname:	Date of birth & Age: &	Last 4 digits of Social Security #:
Home Address:	City:	State:	Zip Code:
Primary Phone #:	Work Phone #:	Additional Phone #:	Email:
Emergency Contact Name (**REQUIRED**):	Primary Phone #:	Additional Phone #:	Relationship:

Parent Information, if patient is a minor:

Parent Legal Name:	Nickname:	Date of birth & Age: &	Last 4 digits of Social Security #:
Home Address:	City:	State:	Zip Code:
Primary Phone #:	Work Phone #:	Additional Phone #:	Email:

Please complete this section when patient's parents reside in different households:

Other (Biological) Parent Legal Name:	Nickname:	Date of birth & Age: &	Last 4 digits of Social Security #:
Home Address:	City:	State:	Zip Code:
Primary Phone #:	Work Phone #:	Additional Phone #:	Email:

Visa or MasterCard Agreement: I authorize FSC to keep this credit card information on file and to charge this credit card for any unpaid balance. I understand that I may cancel this agreement at any time with written notification.

Cardholder Name:	Account #:	Expiration Date:
Security Code (3 digits on back of card):	Zip Code associated with this card:	Signature:

Financial Agreement: I understand Family Success Consortium (FSC) treatment fees are based on $150.00 per clinical hour, including, but not limited to: direct service, reports, phone calls, and additional documentation. I understand the Initial Diagnostic Interview and all psychological evaluation/testing services are based on $200 per clinical hour, including but not limited to direct service, reports, phone calls, and additional documentation. All fees are due at the time of service. I am aware that 24-hour notice is required if I cancel or miss an appointment. I will be charged full fee if I fail to give such notice. I understand returned check fees of $25.00 and billing fees may be applied. I understand FSC does not file insurance claims to private insurance companies.

Medicare/TriCare Policy Holders: Some FSC psychologists are contracted providers and may accept a reduced fee (contracts are term limited). FSC may obtain benefit information but is not responsible for the accuracy of this information provided by insurance companies. I understand it is my responsibility to monitor my insurance benefits, payments and required authorizations. I agree to pay all fees non-reimbursed by my insurance company including, but not limited to: deductible, co-payments, and other miscellaneous fees. Additionally, insurance companies sometimes fail to pay what is expected and I agree to be responsible for such non-reimbursed fees.

I have read and understand these agreements and the HIPPA Ohio Notice form:

Printed Patient Name (Parent's Name for Minors):	Signature:	Date:

Revised 05/18