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PATIENT REGISTRATION

(Please Print)

Today's Date ___/___/___

Patient's Full Name: _____ SS#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Sex: _____ Age: _____ Date of Birth: ___/___/___

Patient Employer: _____ Phone Number: () _____

Student: Y / N If yes High School: _____ College: _____

Family Physician: _____ Referred by: _____

Person to Contact in case of Emergency: _____ Phone: _____

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage.

Full Name of Insured: _____ Relationship: _____ Occupation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Employer and Address: _____ Phone: () _____

Insured's SSN#: _____ Driver's License No. _____

Full Name Spouse: _____ SSN#: _____

Spouse's Employer: _____ Phone: () _____

Insured's Primary Ins. Co.: _____ I.D. No.: _____ Group No. _____

Secondary Ins. Co.: ___No ___YES Company: _____ Policy No.: _____

Job Related Injury- Workmen's Comp. Co.: ___No ___Yes Company: _____

OFFICE BILLING AND INSURANCE POLICY

- 1. I authorize use of this form on all of my insurance submissions.
- 2. I authorize the release of information to my insurance company(s).
- 3. I understand that I am responsible for the full amount of my bill for services provided.
- 4. I authorize direct payment to my service provider.
- 5. I hereby permit a copy of this to be used in place of an original.

Name: _____ I.D. # _____

Signature: _____ Date: ___/___/___

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balances not paid by your ins. the day and time serviced provided.

There will be a \$25.00 service charge on all returned checks.

In the event that your account goes to collections, there will be a 20% collection fee added to your balance.

There is a 24-hour cancellation policy which requires that you cancel your appointment 24-hours in advance between the hours of 8 a.m. to 4 p.m. Monday through Friday to avoid being charged.

Signature: _____ Date: ___/___/___