Kathryn B. Miller, PhD
Licensed Psychologist

Date _____
DX Code _____

Registration Form

Patient Information

Patient Name _____ Date of Birth _____
Last Name First Name Initial

Street Address _____

City _____ State _____ ZIP _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Soc. Sec. # _____ Emergency Contact _____

Sex: ☐ Female ☐ Male Age _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Occupation _____

Referred by _____ May we acknowledge this referral? _____

Primary Insurance

Primary Insurance Company _____ Phone : _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy / Member ID _____ Group/Account # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____ Date of Birth _____ Relationship _____
Last Name First Name Initial

Street Address _____

City _____ State _____ ZIP _____

Soc. Sec. # _____ Employer _____

Secondary Insurance

Secondary Insurance Company _____ Phone : _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy / Member ID _____ Group/Account # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____ Date of Birth _____ Relationship _____
Last Name First Name Initial

Street Address _____

City _____ State _____ ZIP _____

Soc. Sec. # _____ Employer _____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____
Last Name First Name Initial

Address _____ Phone: _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

5101 Olson Memorial Hwy, Suite 4004, Golden Valley, MN 55422 T: 763.595.7294 ext. 114 F: 763.595.7293