

# Greatland Clinical Associates, LLC

Db a Greatland Mental Health, LLC

## OFFICE REGISTRATION FORM

### PATIENT INFORMATION

Name:

Date of birth:

SSN:

DOB

Current address:

City:

State:

ZIP Code:

Male Female Non-binary Other:\_\_\_\_\_

Phone #

Alt Phone #

Emergency Contact Name:

Relationship to Patient:

Phone #

Primary Medical Provider:

Who referred you to see us?

### INSURANCE INFORMATION

Primary Insurance:

Insurance address:

Effective Date:

Phone:

Policy ID:

Group:

Policy Holder:

Policy Holder DOB:

Policy Holder SSN:

Relationship to Patient:

Secondary Insurance:

Insurance Address:

Effective Date:

Phone:

Policy ID:

Group:

Policy Holder:

Policy Holder DOB:

Policy Holder SSN:

Relationship to Patient:

### BILLING NOTIFICATION

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME BY GREATLAND MENTAL HEALTH, LLC DBA GREATLAND CLINICAL ASSOCIATES, LLC (GCA). MY INSURANCE COMPANY WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE INSURANCE INFORMATION TO GCA. **I AM RESPONSIBLE FOR MY PORTION OF THE BILL AT THE TIME THAT SERVICES ARE RENDERED.** I HEREBY AUTHORIZE PAYMENT BY MY INSURANCE DIRECTLY TO GCA. I FURTHER AUTHORIZE RELEASE BY GCA OF ANY INFORMATION NECESSARY TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS

SIGNATURE OF PATIENT

DATE

PATIENT NAME (PRINTED PATIENT NAME)