JULIE LANG L.M.F.T.
405 W. MAIN ST.
GRASS VALLEY, CA 95945-6403

PATIENT REGISTRATION FORM

(please print)

Name _____ Date _____

Date of Birth _____ Age _____ Gender _____

Address_____

City _____ State _____ Zip _____

Cell Phone Number _____ Home Phone Number _____

Work Number _____

Email Address: _____

Marital Status ☐ Single ☐ Married ☐ Other

Guarantor name, cell phone, and email if patient is under 18 _____

_____

Referred By _____

Local Physician _____

Insurance Company _____

Patient ID# _____ Group # _____

Name and Date of Birth of Insured (If other than Patient)

_____

Patient's Relationship to the Insured ☐ Spouse ☐ Child ☐ Other

Please present a copy of your insurance card at the time of your appointment. As a courtesy we will bill your insurance. The patient is responsible for all fees regardless of insurance coverage. Insurance co-payments are due at the time of service. Please be advised that we have a 24-hour cancellation policy. If you do not notify our office 24 hours in advance of missing a scheduled appointment, you will be charged $75.00 for that appointment. (Insurance does not cover missed appointments.) Exceptions may be made in the event of an emergency.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I hereby authorize Julie Lang, L.M.F.T. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Julie Lang, L.M.F.T. all payment for medical services rendered to myself or my dependents. I understand I am responsible for any allowable amount not covered by insurance.

Today's Date _____ Signature _____