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

PATIENT REGISTRATION FORM

(please print)

Name ______________________ Date ____________

Date of Birth ____________ Age ______ Gender ☐ Male ☐ Female

Address ______________________

City ____________ State ________ Zip ________

Home Phone # ____________ Work Phone # ____________

Cellular Phone # ____________

SSN ____________ Driver's License # ____________

Marital Status ☐ Single ☐ Married ☐ Other

Referred by ______________________

Local Physician ______________________

Insurance Carrier ______________________

Patient's ID # ____________ Group # ____________

Name of Insured (If Other than Patient) ____________

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

Insured's Address (If Different from Patient's) ____________

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Insured's Employer ______________________

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

Today's Date ____________ Signature ____________