DR. MARK PARISI & ASSOCIATES, P.C.
HOME PSYCH SERVICES, P.C.

Serving the Behavioral Healthcare Needs of Metro Chicago Since 2000

REGISTRATION FORM

TODAY'S DATE: ____

FULL NAME OF CLIENT: ____

ADDRESS: ____

CITY: ____ **STATE:** _____________ **ZIP CODE:** _________________

CELL PHONE: _________________________________ **WORK PHONE:** _________________________________

E-MAIL ADDRESS: ____

CLIENT'S BIRTHDATE: ___________________ **AGE:** ______ **GENDER: M / F MARITAL STATUS:** ___________

CLIENT'S SOCIAL SECURITY NUMBER: ____

CLIENT'S OCCUPATION: _________________________ **EMPLOYER:** _________________________________

SPOUSE'S NAME: ____________________________________ **WORK PHONE:** __________________________

If client is a MINOR or DEPENDENT, please complete the following section:

FATHER'S FULL NAME: ____ **DOB:** ___________________

FATHER'S PLACE OF EMPLOYMENT:

____

FATHER'S E-MAIL: ____ **CELL PHONE:** ___________________

MOTHER'S FULL NAME: ____ **DOB:** ___________________

MOTHER'S PLACE OF EMPLOYMENT:

____

MOTHER'S E-MAIL: ____ **CELL PHONE:** __________________

If client is a student, what is his/her grade level? ________ **School?** ____

Guarantor Name, if different from above:

____

Guarantor Address, if different from above:

____

IF HEALTH INSURANCE WILL BE USED TO PAY A PART OF YOUR FINANCIAL OBLIGATIONS, PLEASE FILL OUT THE INSURANCE AGREEMENT ON THE NEXT PAGE.

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15 W. Spinning Wheel Rd., Suite 30, Hinsdale, Illinois 60521
Tel. (847) 909-9858 / Fax. (773) 313-3320

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INSURANCE AGREEMENT

Most Third-Party payors (insurance companies) require the provider to release information regarding diagnosis, type and place of service rendered, dates of service, and possibly other related confidential information. Other payors may require a treatment plan and/or a periodic review of services. We are unable to control such information after it has been released and the client or responsible parties should realize that there are social and legal risks posed by the release of confidential information to Third-Party payors.

1. Managed Health Care Plans (HMO's, PPO's, EAP's) may reimburse me for professional services. Special arrangements must be made with the Managed Health Care Plan before a third party source will be accepted.
2. If you expect insurance to reimburse you for your payment, please provide the following information so we can assist you by completing the necessary forms.

A) **PRIMARY** Insurance Company: (*if different than information listed on Registration Form*)

____

Address:

____

Phone Number: ____________ Insurance ID #: ____________ Group #: ____________

Insured's Name: ____________ Insured's DOB: ____________ Employer: ____________

3. Do you know the following benefits associated with your insurance?:

Deductible $________________ Amt. Paid $_____________ Amt. Owed $_____________

Co-insurance %_____________ Est. Amt. $_____________

4. If you want this office to complete insurance forms, we need your signature to authorize release of information to the health insurance company and/or its agents.
5. Since health insurance may be used to pay a part of your obligations, this office may accept insurance as a partial reimbursement. You must authorize the insurance company to make such payments directly to Mark D. Parisi, Psy.D. & Associates, P.C. / Home Psych Services, P.C. However, such an agreement does not release you from the final responsibility for the bill.

I authorize payment of my medical benefits to Mark D. Parisi, Psy.D. & Associates, P.C. / Home Psych Services, P.C., for partial payment for professional services delivered, and agree to an estimated co-payment of _____________ per session charge. The insurance policy's annual deductible must be met before assignment of the policy benefits will be accepted. I acknowledge full responsibility for payment of all professional fees. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to any insurance company, managed care agent, adjuster, or attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

______________________________ ______________________________
(Signature of Client / Responsible Party) (Today's Date)

____
(Printed Name)

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