WEST MICHIGAN PSYCHOLOGICAL SERVICES

259 Hoover, Suite 140
Holland, Michigan 49423

REGISTRATION FORM

Patient Name ____ Date __________
Last First Middle

If patient is a minor, patient lives with ____________________ Relationship ________________

Birthdate __________ Age ____ Sex _______ Social Security # ________________

Address ____
Street City State Zip

Home Phone (____) _________ Work Phone (____) ______________ Marital Status: ____

Occupation ___________ Retired ___ Full-time Student ___ Part-time Student ___

Spouses Name ______________ Social Security # _______________ Birthdate _________

Responsible Party: If Other than the Patient, Please Complete
Name ________________________ Relationship to Patient _____________
Address, if other than same ____
Home Phone (____)_______ Work Phone (____)_________ Social Security #_____________
Responsible Party's Birthdate ________ Employer Name & Address ______________________

Emergency Contact: Nearest Friend/Relative Not Living With You
Name ___________________________ Relationship to Patient __________________
Address ___________________________ Phone (______) ____________

Referring Physician:
Name of Family or Primary Care Physician _________________ Phone # (____)________

Insurance Information:
Primary Insurance Company ______________ Phone # (____)_______ Contract # __________
Subscriber Name Date of Birth_________ Social Security #_________ Group # _________

Insurance Information:
Secondary Insurance Company ______________ Phone # (____)_______ Contract # __________
Subscriber Name Date of Birth _________ Social Security #_________ Group # _________

Financial Responsibility Statement/ Release of Information Authorization

"I authorize West Michigan Psychological Services, LLC to contact my employer and my insurance company in order to verify insurance benefits. I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Provider for services received. I also authorize the release of information to listed physicians and/ or individuals".

X ____ Date ________________
Signature of Patient or Legal Guardian

"I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my provider and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees."

X Date ________________
Signature of Patient or Legal Guardian