Mary Damkroger, Ph.D.
Christian Psychological Services

REGISTRATION FORM

Patient Name: ____
(Last) (First) (Middle)

Address: ____
(Street) (Apt. #)

____
(City) (State) (Zip Code)

Home Phone: __________ Cell Phone: ____________ Work Phone: ________

Social Security #: ______________ Sex: M F Marital Status: S M D W

Email: ___________________________ Date of Birth: __________ Age: _____

IN CASE OF EMERGENCY NOTIFY:
Name: ________________________ Relationship: ___________________
Home Phone: ___________________ Cell Phone: ____________________

GUARANTOR AGREEMENT: I agree to take full responsibility for the entire amount due for any and all services rendered by Mary Damkroger, Ph.D. If she is contracted with my insurance company, I authorized and request my insurance to pay directly to Mary Damkroger, Ph.D. the amount due for services rendered to my dependents or me. As a result, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan.

Signature: ____________________________ Date: ____________________
(Patient/Guarantor)

IF YOU ARE GIVING PERMISSION TO BILL YOUR INSURANCE PLAN, PLEASE READ AND SIGN THE FOLLOWING RELEASE OF INFORMATION: I authorize the release of any mental health information necessary to process insurance claims for services rendered to me or my dependents. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

Signature: ____________________________ Date: ____________________
(Patient/Guarantor)