Celeste Ryane, LCSW
Patient Registration Form

Dx_____ Check benefits? Y N

1. Client Name: _____ DOB: _____
   Gender: □ Male □ Female □ Other

   Address: _____

   City: _____ State: _____ Zip: _____ Phone:_____

   Alternate Contact: _____ Is it alright to leave confidential messages? □ Yes □ No

Email: _____ Email may not be a confidential form of communication. Your email will not be shared or solicited. Listing your email here constitutes permission to send protected health information via email.

2. Primary Insurance Company: _____ ID#_____

   Group # _____ Insurance Phone Number:_____

   Check one of the following: □ Health Insurance □ EAP □ Worker's Compensation □ Auto Insurance

3. Name of Primary Insured: _____ DOB: _____

   Your Relationship to insured: □ Self □ Spouse □ Child/Step-Child □ Other

4. Secondary Insurance Company (If applicable): _____ ID#_____

   Group #_____Insurance Phone Number:_____

   Name of Secondary Insured:_____ DOB:_____

   Your Relationship to insured: □ Self □ Spouse □ Child/Step-Child □ Other

I have been given an opportunity to read the Notice of Privacy Practices, and I hereby authorize Celeste Ryane, LCSW and iMed Billing to provide summary of care and assessment information regarding evaluation and/or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits.

I further authorize payment of medical benefits to Celeste Ryane, LCSW for services provided.

Signed: _____Print Name:_____

Date: _____ Relationship to Client: □ Self □ Other:_____

Office Use Only:
Accessed Benefits _____ Dt ____/____/____ Rep _____Eff ____/____/____

Ded apply? □ yes □ no $ Amount_____ Met_____ Renewal Date ____/____/____ V Limit _____

Copay $_____ Coins %_____Pre-auth required? □ yes □ no OOP _____ Met _____

Eml Benefits. _____/_____/_____ Called ____/____/____ # _____ □ LVM □ Spoke to