Columbus B. Bryant, MSW, Psy.D.

Child and Adult Psychology

REGISTRATION FORM

Name _____
First Middle Last

Address _____

City _____ State _____ Zip _____ Email Address _____

Phone: (Home) _____ (Cell) _____ (Work) _____ Birth Date _____

Name and Phone Number of Nearest Relative (not living with you) _____

_____

Primary Care Physician _____

Referral Source_____

Family Member Information

First Name Last Name Sex Relationship Birth Date

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Responsible Party Information

Responsible Party _____
First Middle Last

Address _____

_____

City _____ State _____ Zip _____

Phone: (Home) _____ (Work) _____ SS# _____

Employer _____

Address _____

Medical Insurance Information

Subscriber Name _____ SS # _____ Subscriber Date of Birth _____

Name of Insurance Company _____

Insurance ID# _____ Group Number _____

Group Name _____ Phone Number _____

Does this plan cover all family members? _____ Yes _____ No

If no please specify those NOT covered. _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Columbus B. Bryant, MSW, Psy.D. for professional services rendered.

Signed _____ Date _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process an insurance claim.

Signed _____ Date _____
(Patient, or Parent if Minor)

Additional Medical Coverage: _____Yes _____ No

If yes, please complete the following:

Subscriber Name _____ SS # _____ Subscriber Date of Birth _____

Name of Insurance Company _____

Insurance ID# _____ Group Number _____

Group Name _____ Phone Number _____

Does this plan cover all family members? _____ Yes _____ No

If no please specify those NOT covered. _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Columbus B. Bryant, MSW, Psy.D. for professional services rendered.

Signed _____ Date _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process an insurance claim.

Signed _____ Date _____
(Patient, or Parent if Minor)