Terasa L. Davis, Psy.D., PC

Registration Form

Patient Name: _____ Patient S.S.# __ __ __ - __ __ - __ __ __ __
Mailing Address: _____ City: _____ St: ____ Zip: _____
Sex: ☐ M ☐ F Age: _____ DOB: _____ Marital Status: _____
Race/Ethnicity: _____ Religion: _____
Home Phone #: _____ Cell Phone #: _____
E-mail: _____

School Attends: _____ Occupation: _____
Employed by: _____ Work Phone #: _____

Emergency Contact: _____ Relationship: _____
Home Phone #: _____ Cell Phone #: _____Work #: _____
Who Referred You? _____

Party Responsible for Payment (if other than patient)
Name: _____ Relationship to patient: _____
S.S.# __ __ __ - __ __ - __ __ __ __ DOB: _____
Home Phone #: _____ Cell Phone #: _____Work #: _____
Address: _____ City: _____ St: ____ Zip: _____
Guarantor's Employer: _____
Guarantor's Employer's Address: _____ City: _____ St: ____ Zip: _____

Do you have insurance? ☐ Yes ☐ No ☐ Self-pay If yes please complete the below information:

Primary Insurance Company: _____ Phone #: _____
Contract/Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relationship to Patient: _____
S.S.# __ __ __ - __ __ - __ __ __ __ DOB: _____
Insurance Claims Mailing Address: _____
Secondary Insurance Company: _____ Phone #: _____
Contract/Policy #: _____ Group #: _____ Effective Date: _____
Policy Holder Name: _____ Relationship to Patient: _____
S.S.# __ __ __ - __ __ - __ __ __ __ DOB: _____
Insurance Claims Mailing Address: _____

Assignment and Release
I, the undersigned, have insurance coverage with _____ (name of insurance company), and assign directly to Dr. Davis all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am finically responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Davis to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I accept the responsibility for payment for the charges not covered by my contract and agree to pay attorney's fees, court costs, and other reasonable cost of collection should I fail to pay for these routine non-covered charges.

Signature: _____ Date: _____