Kress Psychological Services, LLC
755 West Carmel Drive, Suite 201
Carmel, Indiana 46032
Telephone: 317-912-1500
Fax: 317-669-0541
www.kresspsychology.com

REGISTRATION FORM

Patient Name: ______________________________ Gender: _________

Patient Birth Date: ___________________________ Age: __________

Address: ____

City: _______________________ State: ____________ Zip Code: ___________

Telephone Number: ____________________________

Patient's School: __________________________________ Grade: _________

Mother's Name: _________________________________ Birth Date: __________

Email Address: __________________________________

		Leave a message
Home Phone:	_______________________	Yes/No
Work Phone:	_______________________	Yes/No
Cell Phone:	_______________________	Yes/No

Address (if different from patient's address):

____

City: _______________________ State: _____________ Zip Code: ____________

Father's Name: ________________________________ Birth Date: _________

Email Address: ________________________________

		Leave a message
Home Phone:	______________________	Yes/No
Work Phone:	______________________	Yes/No
Cell Phone:	______________________	Yes/No

Address (if different from patient's address):

____

City: ______________________ State: _____________ Zip Code: ____________

Primary Insurance Company: ____

Policy Holder's Name: ______________________Date of Birth: ______________

Insurance ID #: _________________________ Policy/Group#: _______________

Policy Holder's Employer: ____

Policy Holder's Address: ____

Policy Holder's Relationship to Patient: _________________________________

Appointment Reminder:

Email appointment reminder: Yes/No

If Yes, email address(es) to send reminder:

____

Assignment of Benefits and Acknowledgement of Financial Responsibility

I authorize the release of any information obtained and necessary to process an electronic insurance claim. I also assign Dr. Kress payment of insurance benefits for services rendered.

I understand and agree that regardless of the insurance outcome, I am responsible for my account balance for the psychological services Dr. Kress rendered. I also understand that if collection proceedings are necessary for an unpaid account, then I will pay all fees.

____

Printed Name of Patient

____

Signature of Patient (18 years or older)

____

Printed Name of Parent/Legal Representative if Patient is a Minor

____

Signature of Parent/Legal Representative if Patient is a Minor

____

Date

____________________________________ _______________

Signature of Witness Date