Kress Psychological Services, LLC
3021 E. 98th Street, Suite 180
Indianapolis, Indiana 46280
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: _____

Phone: _____Social Security Number: _____

Patient's School: _____Grade: _____

Mother's Name: _____Birth Date: _____

Occupation: _____ 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: _____

Occupation: _____ 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:_____

Secondary 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 to send reminder: _____

Assignment of Benefits and Acknowledgement of Financial Responsibility

I authorize the release of any information obtained in treatment 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