MOHANDESSI PSYCH, LLC

833 SW 11TH AVENUE, SUITE 214
PORTLAND, OREGON 97205
PHONE: (503) 481-9441 FAX: (503) 224-5951

PATIENT REGISTRATION FORM

Demographic Information

Name: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Billing Address (if different from above): _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Social Security Number: _____ Referral Source: _____

Date of Birth: _____

Gender: F M O

Marital Status: _____

Emergency Contact Person: _____

Contact Relationship: _____

Contact Phone: _____

Payment Method

__ Cash __ Check __ Debit __ Credit

Insurance Information

Mohandessi Psych, LLC will bill your medical insurance company for services rendered. You are responsible for any fee, co-pay, or co-insurance at the time of your appointment. Any charges within your insurance deductible will also be your responsibility to pay at the time of service. In addition, if your insurance does not pay for the services rendered, you will be responsible to pay your balance within 30 days of receipt of an invoice from Mohandessi Psych. LLC. If you do not pay within 30 days of the date of service or invoice, you will be charged a $50 late fee and be subject to 1.5% monthly interest on any outstanding balance. Your insurance will not pay for these charges nor will they pay for missed appointments.

Insurance Company: _____

Policyholder's Name: _____ DOB: _____

Relationship to Insured: Self Spouse Child Other _____

Plan Name: _____

Policy Number: _____

Group Name: _____

Customer Service Number: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE AND ANY OUTSTANDING BILL FOR SERVICES RENDERED.

_____

Patient Name—Print

_____ _____

Patient Signature Date