

**Kathryn Neraas, M.D.**  
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## REGISTRATION

Today's date: \_\_\_\_\_

<b>Name:</b> _____	<b>Age:</b> _____
<b>Social Security #:</b> _____	<b>Date of Birth:</b> _____

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ May we contact you at work?  Yes  No

Home Phone: \_\_\_\_\_ May we contact you at home?  Yes  No

**Preferred phone for us to contact you:**  Cell  Home  Work

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

Partner's Name (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to me? \_\_\_\_\_ May I thank them? \_\_\_\_\_

### INSURANCE INFORMATION:

Do you want me to bill your insurance?  Yes  No

Have you called your insurance to verify your mental health benefits?  Yes  No

Preauthorization Required?  Yes  No Annual deductible: \_\_\_\_\_ Deductible met?  Yes  No

Sessions/year: \_\_\_\_\_ Co-pay: \_\_\_\_\_ Co-insurance: \_\_\_\_\_

1. **Primary Insurance name:** \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

2. **Secondary Insurance name:** \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

### FEE AGREEMENT AND RELEASE

\_\_\_ I assign payment of insurance benefits directly to Dr. Neraas.

\_\_\_ I authorize the release of all information necessary to process this claim and authorize the use of this signature on all insurance submissions.

\_\_\_ I understand that payment for services is ultimately my responsibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date