DORIT ATAR, LLC CLIENT REGISTRATION FORM

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone #: _____ OK to send appointment text reminders? Yes No

Email:_____

Date of Birth: _____/_____/_____ Sex: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other: _____ Age: _____

Emergency Contact: _____ Phone #: _____

Who do we thank for referring you?_____

Using Insurance?

_____ NO (Self pay rate $150 per 50 minutes session)

_____ YES (please fill out the following)

Insurance: _____Telephone #: _____Policy No.: _____

Group No.: _____

Policy Holder Name: _____ Relationship: _____ DOB:_____

TO BE COMPLETED BY BILLING OFFICE

Circle one: In Network Out of Network

Policy Effective: _____ Copay Per Visit: _____ Self Pay: Y N $_____

Deductible Amount: $_____ Deductible Met: $_____

Claims Address: _____

LATE CANCELLATION / NO-SHOW POLICY

In the event that you are unable to keep an appointment, please notify us **at least 24 hrs in advance**. You will be charged the insurance allowable rate, or the session fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

ACKNOWLEDGEMENT AND CREDIT CARD AUTHORIZATION

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Dorit Atar, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered, as well as any additional collection agency fees should their assistance become necessary. I authorize Dorit Atar, LLC to file a claim for these services (and to refile as necessary to collect) with my insurance(s) and bill me for any amounts for which I am responsible or for which insurance will not pay or deny. I further authorize Dorit Atar, LLC to sign said claim(s) or any re-filed claim on my behalf.

You are welcome to pay using either cash, check, Venmo, Zelle, or credit card. By filling out your credit card information below you agree for your credit card information to be kept in your confidential file and used to pay for payments, co-pays, denied insurance claims, late cancellations and/or no-shows. Receipts and payment explanations will be available by request.

CREDIT / DEBIT (AE, Visa, Mastercard, including HSA/FSA cards):

Card # _____ _____ _____ _____ CV CODE _____ EXPIRATION DATE _____

NAME ON CARD_____

BILLING ADDRESS_____

_____

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: _____ Signature: _____

Date: _____