**PATIENT REGISTRATION FORM**

ALL sections of this form MUST be completed and signed.

## PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Street Address (No PO Boxes) _____

City _____ County _____ State _____ ZIP Code _____

Home Phone _____ Social Security _____ Birth Date _____ ☐ Male ☐ Female

## RESPONSIBLE PARTY (Person completing and signing this form.)

☐ Same as Patient

First Name _____ Middle Initial _____ Last Name _____

Mailing Address _____

City _____ County _____ State _____ ZIP Code _____

Home Phone _____ Social Security _____ Birth Date _____ ☐ Male ☐ Female

Place of Employment _____ Work Phone _____ Email Address _____

**FINANCIAL AGREEMENT**

I understand that Dr. Johnson is not an employee of Ridge Creek School and will bill me separately for his professional services. I hereby assume full responsibility for all charges incurred for professional services by Dr. Johnson. **I understand that I will need to pay Dr. Johnson directly, then I will need to submit claims to my insurance company for reimbursement.**

**The Fees as detailed by Dr. Johnson are:**

Initial Evaluation $250, 15-20 min follow-up $125
Phone contact <10 minutes FREE, >10 minutes $25, >20 minutes $50
Email responses(first 1 free) $15, Medical Records request $30

**GROUP & INDIVIDUAL INSURANCE/ASSIGNMENT OF BENEFITS**

I understand that Dr. Johnson will authorize my health insurance benefit plan to pay directly to me the medical benefits, but not to exceed his charges for those services. Dr. Johnson will submit to me a copy of all information needed to submit to my carrier in order that I get paid. This will include dates of service, procedure code, diagnosis code and all other information needed. I understand that I will receive an invoice for services after each appointment.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Dr. Johnson to release any medical or psychiatric information to my referring physician(s) and any insurance company with whom I have medical benefits for the purpose of filing a claim. I acknowledge that this authorization is valid until such time as all medical bills have been paid. I further understand that I can withdraw this consent for release of information at any time except to the extent that action has been taken in reliance hereon. I also authorize the release and exchange of information between Dr. Johnson and RCI. (NOTE: Dr. Johnson is fully compliant with the new HIPAA regulations as required by law.)

Signature:_____ Date:_____

**CONSENT FOR TREATMENT**

I hereby consent to treatment by psychiatrist Martin Johnson, MD for mental health services and/or related medical services. I understand that my care and treatment may include mental health assessment, medical assessment, diagnostic testing, individual, group and/or family counseling and therapy, medication prescription, general psychiatric care and treatment, and related standard mental health therapies. Medication prescription may include a weaning schedule of psychotropic medication, or it may include continuation of psychiatric care and medication management.

Student/Patient signature_____

Parent/Guardian signature (if student is a minor_____ _____

Date:_____