BIANCA M. KAZOUN LLC

PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Referred by:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Cell or Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Email: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BIANCA M. KAZOUN LLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Bianca M. Kazoun LLC

80 Park Street Montclair, NJ 07042 Ph: 973-794-3402 biancalpcservices@gmail.com

Office Policy

Please familiarize yourself with our office policies. If you have any questions, please call our office or your doctor.

Insurance

1. Patients are responsible for being aware of current insurance coverage. This includes the details of:
• Out of network benefits
• Deductible and/or "out-of-pocket"
• Need for pre-certification
• Current coverage and co-payment
• Maximum annual visits
• Current visits remaining
• Any changes in coverage
2. If you have exceeded your benefits covered you are responsible for the full payment for any uncovered sessions.
3. Your mental health coverage may be "carved out" to other managed care companies. We are considered out-of-network with those companies.
4. Please note that your insurance may place limits on the number of visits allowed per calendar year. This may not be sufficient to cover the clinically appropriate level of care determined by your provider.

3. Please inform your physician about needed refills at least 3 business days before your medication runs out. Set aside an emergency reserve of 3 to 5 days of each prescription .

Cancellations

1. Because your appointment time has been reserved for you, you will be charged for cancellations with less than 24 hours (one business day) notice. For example, if your appointment is scheduled on a Monday or following a long weekend, please call on the preceding Friday.
2. Charges for missed appointments are not covered by your insurance and are due and payable prior to any further appointments. Please note that such charges include the amount normally covered by the insurance company in addition to the copay amount.

Telephone Calls

1. Please leave your full name and phone number with your message. Please leave the best time of day to call.

Payment

1. Payment is expected at the time of appointment. We accept cash, checks, Visa or Mastercard.
2. Requests for written reports or records may incur additional charges.
3. There is a $50 charge for returned checks.

Patient name:

Birth date:

Signature:

Date:

Relationship to patient (if signed by authorized representative) _ parent _ legal guardian _ other:

I have received a copy of the office policy of Bianca M. Kazoun LLC and agree to the terms within.