M. Hope Rollins LCSW, PLLC

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

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?	Social Security No:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.: ( )	Cell phone no.: ( )

City:	State:	ZIP Code:	

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

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	❑ BCBS	❑ BCBS State PPO	❑ CIGNA	❑ United Behavioral Health	❑ Tri-care

❑ United Healthcare	❑ Medicare	❑ [Insurance]	❑ 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 (not living at same address):	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 M. Hope Rollins LCSW,PLLC or insurance company to release any information required to process my claims.

Patient/Guardian signature _Date_

Spouses Name/Parent's (if a minor):

____

Name/Age/Sex of Children:

____

Name/Age/Sex of Siblings:

____

HAVE ANY OF YOUR RELATIVES HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY.

	Patient	Relatives (Specify)
Eye trouble; including Glaucoma		
Anemia		
Ear, Nose, Throat Trouble		
Epilepsy		
Asthma, Hay Fever, Hives		
Tuberculosis		
Respiratory Infections		
Heart murmur, Heart Disease		
Rheumatic Fever		
Increased Blood Pressure		
Stomach or Intestinal Trouble		
Hepatitis		
Kidney or Bladder Disease		
Injury or Disease of Bones or Joints		
Surgery		
Diabetes		
Mononucleosis		
Frequent or Severe Headaches		

FEMALES ONLY

	Patient
Irregular Periods	
Severe Cramps	
Excessive Flow	
Last Monthly Period	
Are you pregnant now?	
Incomplete Pregnancies	

PREVIOUS PSYCHIATRIC CARE

Doctor or other therapist	
How long were you seen (months; years)?	
Frequency of sessions	

List all medications taken in the past 3 months:

____

List all medications being taken presently:

____

Date of last physical exam:

____

Doctor's name and address:

____

PLEASE LIST ALL ALLERGIES:

____

NOTICE TO PATIENTS

OFFICE HOURS:	Hours are by appointment only.
OFFICE CHARGES:	Payment is expected at the time of service. We accept payments in the form of Cash, Check, MC, Visa & Discover. There is a $25.00 fee for returned checks.
CANCELLATIONS:	Because appointment times are reserved for you and it is difficult to fill that time, please give **24 hours notice** of cancellation. If you fail to keep your appointment or cancel without 24 hours notice, you will be charged a $50 missed appointment fee. The 24 hours notice also applies to appointments scheduled on Mondays – those appointments must be cancelled no later than Friday.
TELEPHONE:	All calls are personal and confidential. Feel free to leave a message at either (919) 239-4588 or (919) 741-1417.
EMERGENCIES:	For immediate assistance or life threatening emergencies dial 911. If you need additional assistance contact me a 919-741-1417. All messages are personal and confidential
CONFIDENTIALITY:	Every effort is made to preserve confidentiality of all patients in this practice. I ask that each patient not disclose the identity of any other patient(s) being seen here. Other than giving diagnoses to insurance companies for billing purposes, no information will be released without your prior knowledge and written consent. I will discuss each situation with you individually if the occasion arises.
INSURANCE:	We do file insurance; however, confirmation of benefits and pre-approval (pre-authorizations) prior to services are the patient's responsibility. Co-payments are expected at the time services are rendered.

______________________________ Signature

________________________ Date

M. Hope Rollins LCSW, PLLC
1405 Hillsborough Street, Suite 101
Raleigh, NC 27605
Tel: (919) 239-4588

Fax: (919) 516-0558

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