Alyssa M. Revuelta, PhD
Licensed Clinical Psychologist
523 Live Oak Drive
Mt. Pleasant, SC 29464

Patient Registration Form

Date: _____

Patient's First Name: _____ Last Name: _____ MI: _____

Date of Birth: ____/____/_____ Age: _____ Gender: ____ F ____ M

Current Grade: _____ School: _____

Name of Parent(1)/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (____) _____ - _____

Occupation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: (_____) _____ - _____

Email: _____

If parents are separated or divorced, who has legal custody of this child? _____

Name of Parent(2)/Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (____) _____ - _____

Occupation: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: (_____) _____ - _____

Email: _____

Referred by: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Information (for BCBS carriers only)

Primary Insurance: _____ Subscriber: _____

Phone: _____ Subscriber Date of Birth: _____

Contract/ID#: _____ Patient's Relationship to Subscriber:

Group/Acct#: _____ ___ Self ___ Spouse ___ Child ___ Other (_____)

_____ (initial here). **Authorization to file insurance claims:** I authorize Alyssa Revuelta, PhD to file my insurance claims and I hereby authorize the release of any psychiatric, psychological, or other medical information to process those claims.

_____ (initial here). **Authorization to pay insurance benefits:** If I have not paid my visits in full, then I hereby now and forever authorize and direct all payment(s) to be made directly to Alyssa Revuelta, PhD who rendered service for the benefits payable from all plans of health insurance or benefit programs otherwise payable to me. A copy of this is as valid as the original.

Payment:

Payment is due at the time of service. Insurance companies require collection of deductibles and co-pays at the time of service. Specific coverage varies by plan and service. Self-pay patients are also required to pay at the time of service.

Person Responsible for Payment: _____

Signature of Person Responsible for Payment X_____

For appointment reminders, I would prefer the following: ___ Phone ___ Email ___ Text Message

Emergency Contact Information
In case of emergency, contact:

Name: _____ Relationship: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Other: (_____) _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____