Pacific Sunrise Psychological Services
Kristi L. Mueller, Psy.D.
Clinical Psychologist
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(808) 859-2017

REGISTRATION FORM

NOTE: *All information will be kept in a secure location and none of your information will be shared with anyone without your written consent.*

PATIENT INFORMATION:

First Name: _____ MI: _____ Last Name: _____

Address: _____

Date of Birth: _____ Age: _____ Gender: M F SSN _____

Cell Phone: _____ Other Phone: _____
OK to leave a message? YES NO OK to leave a message? YES NO

Email Address: _____

How would you like appointment reminders to be sent to you?

- ☐ Email to: _____
- ☐ Text Message to: _____
- ☐ Phone Call to: _____
- ☐ None (no reminder will be sent)

Marital Status: Married Single Divorced Legally Separated Widowed Domestic Partner
(please circle one)

Employment Status: Employed Disabled Retired Student Not Employed
(please circle one)

Employer (or school): _____ Occupation: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Phone: _____

Relationship to you: (e.g., spouse, mother, aunt, etc.) _____

*** This contact will only be used if I believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.*

REFERRAL INFORMATION:

Referring Provider/Physician: _____ Phone: _____

*** By providing this information, you are allowing me to contact the referring provider with treatment-related updates.*

INSURANCE INFORMATION: ** Please complete this section if you will be using insurance for your sessions.*

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Relationship to patient: (circle one) Self Spouse Child Mother Father Grandparent Other

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

Insured's Address: _____

Insured's SSN: _____ Insured's Date of Birth: _____ Gender: M F

Insured's Employer: _____

Secondary Insurance: _____ **Policy #:** _____ **Group #:** _____

Relationship to patient: (circle one) Self Spouse Child Mother Father Grandparent Other

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

Insured's Address: _____

Insured's SSN: _____ Insured's Date of Birth: _____ Gender: M F

Insured's Employer: _____

ASSIGNMENT AND RELEASE:

My signature below certifies that the above information is true to the best of my knowledge.

In addition, I agree to the following, if applicable:

- I authorize use of this form on all of my insurance submissions
- I authorize the release of information to my insurance company(s) and medical biller if used (electronic billing)
- I understand that I am responsible for the full amount of my bill for services provided
- I authorize direct payment to my service provider
- I hereby permit a copy of this to be used in place of an original
- I understand that it is the patient's responsibility to pay any deductible amount, co-pay, co-insurance amount, or balance not paid by the insurance on the day services are provided
- I understand that there is a $25 service charge on all returned checks

_____

Client signature

_____ _____

Printed Full name of Client (please print) Date

_____ _____

Kristi L. Mueller, Psy.D. Date