Welcome!

REGISTRATION FORM

Lawrence M. Raines, III, M.D.
Adult & Addiction Psychiatry

Section I: **PATIENT INFORMATION**

Date___________Name:____ I Prefer to be called:____________________________

Address:____City:________________State:___________Zip_____________

CELL Phone (______)________________ HOME Phone (______) __________________ WORK Phone (_____)_____________

Occupation:__________________________________ Employer:____

The best time to contact me is:_________________________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:___________________________________ Social Security Number:_____________________________________

DRIVER'S LICENCE NUMBER AND STATE OF ISSUE:____
Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School_______________________________ City/State______________________________ ☐ FT ☐ PT

Spouse or Parent's Name:____Phone: (_____)______________________

Who may we thank for referring you? ____

Person to contact in case of emergency____ Phone:(_____)_________________

EMAIL (Non-WORK if available for privacy):

Is it OK to contact you about appointments via email with the APPOINTMENT PLUS HEALTHCARE system? Yes No

Section II :*(Required completion prior to treatment)*: **FINANCIALLY RESPONSIBLE PARTY**

I agree with the *Financial Policy for Lawrence M. Raines, III, MD* as outlined in the Policy and Procedures and agree to have my credit card charged to pay for treatment , to include session charges, telephone consultation charges, missed appointment fees, late appointment cancellation fees, other incurred fees, such as banking fees, returned check fee of $35.00, medical record fees, letters, reports, etc. If I am paying for a child, spouse, family member, or friend, I understand that agreeing to pay for treatment does not create an obligation to Dr. Raines or the practice to divulge treatment details without the written consent of the person (if over 18 years of age) receiving treatment.

Printed Name:__________________________/*Signature:*__________________________________Date:____________

Billing Address (for all following, if different from above):____

City:___________________ State:__________ Zip:_____________ Home Phone: (____)__________________________

Employer____Work Phone (____)________________________________

Section III **INSURANCE INFORMATION**

(Although Dr. Raines as a PLLC is Out of Network, this information may be required for medication prior authorizations, etc.)

Name of Insured *(all following info IF different from above)*:____DOB:_______________Relationship to Patient ______________

SSN#:_________________________ Name of Employer:_____________________ Work Phone: (____)__________________

Address of Employer:________________________________City__________________State:______________Zip ___________

Insurance Company:_____________________ Grp #:_________________________ ID#:____________________________

Ins Co Address:___________________________________Ins Co. Phone:_____________________________