Patricia M. Conway, PsyD, RN, MS

Licensed Clinical Psychologist

REGISTRATION FORM

Name **Date of Birth**

Address

Street
City
State
Zip
Home Phone
Cell Phone
Work Phone
Email

Note — Email is optional and will only be used for brief correspondence regarding scheduling, insurance information, etc. No clinical information will be communicated via email.

Billing Address (if different)

If you are a student, please give your home address.

Street
City
State
Zip
Phone

Primary Insurance Co
Subscriber Name
Date of Birth
ID Number

Secondary Insurance Co
Subscriber Name
Date of Birth
ID Number

Primary Care Physician

Psychopharmacologist

Medications

History of Mental Health Services

Hospitalizations

AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby direct my insurance company to make payments directly to Patricia Conway, LICSW for health insurance benefits otherwise payable to me, but not to exceed regular charges. I understand that I am financially responsible for charges not covered by this authorization including co-payments and deductibles. I also understand that it is my responsibility to obtain any necessary pre-certification of treatment prior to my first appointment.

Additionally, I authorize Patricia Conway, LICSW to release billing and medical information to my insurance company necessary to process claims for services rendered to me by Patricia Conway. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information which by law may only be released by specific consent.

Signature of Client/Guardian _____ **Date**