Registration Form

McCourt Associates, Inc.

Anna McCourt, MA, LP

Date_____ **Prim DX** _____

Patient Information

Patient Name (Print)_____ **Date of Birth**_____
Last Name First Name Initial

Street Address_____ Home Phone: _____

City_____ State_____ ZIP_____ Cell Phone: _____

Soc. Sec. #_____ Work Phone: _____

Sex: ☐ Female ☐ Male Age_____ Relationship Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Employer _____ Occupation_____

Referred by_____ May we acknowledge this referral?_____

Primary Insurance

Primary Insurance Company_____ Phone { }_____

Ins Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
Last name First Name Initial

Address_____ City_____ State_____ Zip_____ **Date of Birth**_____

Soc. Sec#_____ Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone { }_____

Ins Claims Address_____ City_____ State_____ Zip_____

Policy/ID #_____ Group/Plan #_____
(This is sometimes the Policy Holder's social security number.)

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____ Relationship _____
Last name First Name Initial

Address_____ City_____ State_____ Zip_____ **Date of Birth**_____

Soc. Sec#_____ Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____

Address_____ Phone { }_____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date