Date Completed: _____/_____/_____

PATIENT REGISTRATION FORM

Dr. Carolyn R. Craft, Psychotherapy - License# NCFBPPC85
3904 Hope Valley Rd., Durham, NC 27707, Phone: 919-612-8899

(Please fill in ALL information including all detailed Insurance information on second sheet.)

Patient's Full Name: _____

Address: _____

City: _____

State: _____Zip:_____

Home/Cell Telephone: _____

Work Telephone: _____

E-Mail Address: _____

Birth Date: _____

Marital Status: _____

Sex: (optional) Female/Male/LGBTQ

Social Security Number: _____ _____ _____

Employment Status: Employed Unemployed Student

Name & Address of person responsible for payments (if different from above):

_____

_____

Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Policy Holder (if different from above): _____

Address of Policy Holder: _____

Policy Holder's Home Phone: _____

Work Telephone: _____

Policy Holder's Employer (Please note, while Dr Craft is in-network with NC BCBS, her license: NCFBPPC85 is accepted in only seven (7) states. If your insurance is through your Employer and the home office is located in a state where her license is not valid; in-network NC Blue Cross Blue Shield claims will not be reimbursed and clients will be responsible for full payment):_____

Patient's Relationship to Policy Holder: Self Spouse Child Other

Policy Holder's **Birth Date:** _____

Insurance Company: _____

Ins. Co. Address: _____

City: _____**State**:_____Zip:_____

Policy Number: _____

I.D. Number: _____

Group Number/Name: _____

Is Policy Holder employed & insured under employer's health plan? YES NO
Policy Holder's insurance deductible? _____ **Has deductible been met?** YES NO
Does insurance company require that outpatient mental health benefits be preauthorized? YES NO
If YES, have you obtained **preauthorization?** YES NO
Does Policy Holder want Dr. Carolyn R Craft, Psychotherapy to file? YES NO
Does Policy Holder want to file with their insurance company? YES NO
Health plan's phone number(s) for
Benefits' information and preauthorization: _____

Please read and acknowledge your understanding by signing this statement of authorization:

I hereby authorize the release to my insurance company of any medical information necessary to process claims for services provided by my therapist at Dr. Carolyn R. Craft, Psychotherapy. I authorize payment of medical benefits to Dr. Carolyn R. Craft, Psychotherapy. **I agree that I am responsible for any balance not reimbursed by insurance.**

_____ _____
Signature of Patient or Responsible Party Date