Rockford Anxiety and Phobic Clinic

Charles Dudley, Jr., M.Ed., NCC, LCPC
Rockford, IL 61108

REGISTRATION FORM

Date: ____________________

Patient Name: ____ **Primary Doctor:**_______________ **Referred By:**_____________
(Last) (First) (MI)

Address: ____ **City:** ______________________ **State:** ________ **Zip:** __________

Date of Birth: ___________ **Age:** ____ **Sex:** ______ **SSN:** _______________ **Email:** ________________________________

Marital Status: ___S ___M ___D ___W **Home Phone #:**_________________ **Cell #:** ________________ **May We Text You?** _____

Employer: __________________ **Work Phone #:** ___________ **Employer Address:** _______________________________________
(City) (State) (Zip)

Emergency Contact Name: ______________________________ **Phone #** _________________ **Relationship:** ___________________

RESPONSIBLE PARTY INFORMATION

Name: ____ **Relationship to Patient:** __________________________________

Address: ____ **City:** ______________________ **State:** ________ **Zip:** __________

Date of Birth: _____________ **Age:** _______ **Sex:** ________ **Social Security #:** _______________________________________

Employer Name: _____________________________________ **Employer Phone #:** ______________________________________

Employer Address: _______________________________ **City:** ______________________ **State:** ________ **Zip:** __________

PRIMARY INSURANCE

Name of Insured: _________________________________ **Relationship to Patient:** __________________________________

Insured Date of Birth: ____________________________ **Effective Date of Coverage:** _______________________________

Insurance Company: ______________________________ **Policy #:** _____________________ **Group #:** ________________

Address: __________________________________ **City:** _________________ **State:** ____ **Zip:** ________ **Phone:** ____________

SECONDARY INSURANCE

Name of Insured: _________________________________ **Relationship to Patient:** __________________________________

Insured Date of Birth: ____________________________ **Effective Date of Coverage:** _______________________________

Insurance Company: ______________________________ **Policy #:** _____________________ **Group #:** ________________

Address: _______________________________ **City:** ____________________ **State:** ____ **Zip:** ________ **Phone:** ___________

I hereby authorize release of information from RAPC and Empathic Suites, LLC to file a claim with my insurance and assign benefits otherwise payable to me to be paid to the Provider indicated on this form.

I authorize the Provider, **Charles Dudley, Jr.**, and his agents to provide medical records to insurance companies as necessary.

I agree that any fee for service not covered by insurance will be paid at the time of service including co-pays and co-insurance.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

A copy of your Driver's License or State ID will be kept on file. Thank you.
NOTE: Appointments not cancelled 24 hours in advance will be charged at regular price.

Signature (Patient or Guardian) ____ **Date**