Sarah Stewart, Psy.D., PLLC

Licensed Psychologist

Patient Registration Form

Patient Information

Name _____

Address _____

City, State, Zip _____

Home Phone Work Phone _____

Date of Birth _____

Name & Address of Person responsible for charges

_____

_____

Authorization for Release of Information

I hereby authorize the Provider and his/her billing staff to release any billing and medical information to my insurance company necessary to process claims for services rendered to me by the Provider. 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 Patient/Guardian: _____Date:_____

Dx _____

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