Welcome! Patient Registration

CARLA DORSEY MD

Section I

Name _____ Date of birth _____

Street address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Work phone _____ Email _____

Preferred method of contact ☐ Home phone ☐ Cell phone ☐ Email ☐ Text

Social security number _____ Employer _____

Insurance carrier _____ ID number _____

Primary policyholder's name _____ (We will copy your insurance card for pharmacy services.)

Emergency contact name _____ Phone _____

Preferred pharmacy _____ Phone _____

Street address _____

City _____ State _____ Zip _____

How were you referred to Dr. Dorsey? _____

Section II

Relationship to patient (self, spouse, significant other, parent, other) _____
(If self, leave remainder of this section blank.)

Name _____ Phone _____

Street address _____

City _____ State _____ Zip _____

Section III

Signature _____ Date _____

Financial Agreement

The responsible party must pay for all professional medical services provided by Carla Dorsey MD at the time of service delivery. Dr. Dorsey's current rates are available upon request. Once payment is rendered, the patient will be issued a receipt that he/she can then submit directly to his/her insurance company for out-of-network reimbursement. This office does not offer the courtesy of direct insurance billing. It is the patient's responsibility to understand his health insurance policy benefits regarding out-of-network mental health benefits. We will work with you to maximize your insurance reimbursement and correct any receipts which have been rejected by your insurer.

Cancellations must be made 48 hours in advance. Other than in the case of an emergency or act of God, you will be billed for the missed session. Although Dr. Dorsey is not in the office every weekday, the office phone is answered, usually in person, throughout the entire work week including after hours. There is also a voice message option. Please see our Policies and Procedures for more detailed information.

Non-clinical work includes time spent filling out forms, lengthy telephone or email discussions with the patient or other involved professionals, composing summary letters as requested by the patient or other providers involved, and others. These activities will be billed directly to the patient at the rate of $25.00 per ten minute segment. Insurance may not provide the patient with reimbursement for these charges.

Responsibility for personal property is not the duty of Dr. Dorsey or her staff. I, the undersigned, do hereby release the healthcare provider from any and all responsibility relative to the loss of, and/or damage to, any personal property.

Signature certification below indicates that the information given here is correct and understood. By signing, you are certifying that you are the patient, or the patient's responsible party, and that you accept in full the terms of this agreement as well as the Procedures and Policies and Privacy Policy forms.

Patient signature (or responsible party) _____

Print name _____ Date _____

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