REGISTRATION FORM

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Client: _____ Parents: _____

Address: _____
(street) (city) (state) (zip)

Telephone: Home _____ Work: _____

Date of Birth: _____ Social Security # _____

Occupation: _____ Employer: _____

Employer Address:_____
(street) (city) (state) (zip)

Nearest Relative or Friend: _____ Telephone: _____

Referring Physician: _____ Telephone: _____

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PAYMENT AND INSURANCE POLICY

Clients are responsible for payment for service. Your insurance contract is between you and your insurance company, not between the doctor and the insurance company. As a service, we will bill your insurance company to help you receive maximum benefits. If there is no insurance coverage, for whatever reason, or should existing insurance fail to cover the entire charges, the unpaid balance is due on the date or service or by the end of each month. Accounts outstanding over sixty (60) days will be subject to a **$10.00 per month late charge**. Legal expenses or other costs incurred in collecting delinquent accounts will be your responsibility.

_____ PRIVATE PAY: I will pay the full amount at the time of service or at the end of each month.

_____ INSURANCE: My insurance company will be billed for services. I will pay the portion of charges not covered by my insurance company at the time of service or at the end of each month.
It is expressly understood that only **one** insurance company will be billed.

Name of Insured: _____ Relationship to Client: _____

Is Insurance
Through Employer? _____ If Yes, Employer: _____

Insurance Company: _____ Occupation: _____

Group Number: _____ Individual or Subscriber Number: _____

Insurance Address: _____
(street) (city) (state) (zip)

Insurance Telephone: _____ Other Health Insurance? _____ List information on other side.

DX: _____ # _____

I have read and understand the above policy and make this agreement with the understanding that I accept full responsibility and liability for all charges incurred and guarantee a timely payment of agreed upon charges and late fees, if applicable.

Signature: _____ Date: _____

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RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby request and authorize Stephen F. Emiley, Ph.D. to release any health related information which might be needed in connection with payment of services rendered. I request that payment under my health insurance policy be made directly to Stephen F. Emiley, Ph.D. on any bills for services provided me by Stephen F. Emiley, Ph.D. A copy of this release of information and assignment of benefits shall be as valid as the original.

FEE per Service Hour: $160.00

Signature: _____

Date: _____

Dr. Stephen F. Emiley
5800 N. Bayshore Drive Suite A-230
Glendale, WI 53217
(414) 961-0030