*The Office of Kevin Harrington, Ph.D., L.P.*

# Adult Registration Form

Date_____

Patient Name (Print) _____Date of Birth_____
Last First MI

Address_____
Street City State Zip

Home Phone_____OK To Call?____Yes _____No

Cell Phone_____ Ok To Call?____Yes _____No

Work Phone_____ Ok To Call?____Yes _____No

E-mail_____

Emergency Contact_____Phone_____

Name of Spouse (If applicable) _____ Who Referred You?_____

**Primary Insurance**

Primary Insurance Company_____ Phone_____

Insurance Claims Address_____ City_____ State_____ Zip _____

Policy/ID #_____ Group/Plan #_____

Policy Holder Information (if the patient is not the employee/policy holder)

Name_____ Relationship_____
Last First MI

Address_____ City_____ State_____ Zip_____

**DOB_____ Employer_____**

## CONSENT FOR THE RELEASE OF PRIVATE INFORMATION TO INSURER

I/We hereby authorize Kevin Harrington ,Ph.D,L.P. to disclose to the Insurance carrier, the following information: a statement of my diagnosis, the services I/We received, the person's providing and supervising these services, the dates of service, and any required narrative. The insurer and provider of services will use this information to process and/or determine reimbursement for services provided.

I/We understand that no other information will be released and no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purpose stated above. I/We understand that this consent may be revoked at any time, and in any event, it expires automatically as described below.

This consent expires within one year of this date or when the purposes for which it was granted have been accomplished, whichever occurs first. A copy of this authorization shall be as valid as the original. I hereby authorize payment of medical insurance benefits to Kevin Harrington,Ph.D.,L.P. for services rendered to me and/or my dependents.

***SIGNATURE***_____ ***DATE***_____