Stephen M. Hjemboe, Ph.D., Licensed Psychologist
2233 North Hamline Avenue, Saint Paul, Minnesota 55113

REGISTRATION

Name :_____ **Age:**_____ **Birthdate:** ____/____/_____
First Middle Last Month/Day//Year

Current Address *Street address City State Zip*

Permanent address, *if different from above City State Zip*

Preferred Contact Phone: (____)_____**Secondary Phone:** (_____)_____

Email is preferred for quick communications, changing appointment times, and sending billing statements.
☐It's OK to contact me by email. Here's my address: _____
☐It's NOT OK to contact me by email/ I don't have an email address.
☐I prefer to save paper and get billing statements by email

Occupation _____**Employer**_____

Marital Status: _____ **Partner's Name:** _____ **Names and ages of children:**

_____

_____

Emergency Contact: _____ **Relationship to you**: _____**Phone**_____

Primary Care Physician: _____ **Clinic:**_____**Phone**_____

Psychiatrist: _____ **Clinic:** _____**Phone**_____

Who referred you, or how did you find this practice?)_____

INSURANCE

Primary Insurance

Insurance Name:_____**ID#:** _____**Group #**_____

Relationship to Subscriber: _____ (If not yourself, please complete the next line):

Subscriber: _____**Birthdate:** ____/_____/_____ **Employer:** _____

Secondary Insurance (*If applicable)*

Insurance Name:_____**ID#:** _____**Group #**_____

Relationship to Subscriber: _____ (If not yourself, please complete the next line):

Subscriber: _____**Birthdate:** ____/_____/_____ **Employer:** _____

Reminders: A photocopy of your insurance card will be required. Any copayment must be collected at time of service.

Please continue on Side 2 →

The purpose of this form is to obtain your consent to administer care and to share your health and personal information as necessary to process bills or claims, carry out functions that support treatment, coordinate your care with other providers, and to assign your health plan benefits to Dr. Hjemboe.

CONSENT FOR TREATMENT

I authorize Stephen Hjemboe, Ph.D. LP to administer care and treatment to me and to perform diagnostic procedures and tests or other treatment considered necessary and advisable by him. I have been given and have read **Patient Information: Office Policy, Privacy, and Informed Consent**, and agree to those stated conditions.

RELEASE INFORMATION

I authorize Stephen M. Hjemboe, Ph.D., L.P. and/or his billing agent to disclose as needed to my insurance company, health service plan corporation, health maintenance organization, billing agent, or third party administrator, information from my health records, including information relating to my identity, diagnosis, treatment and prognosis, for purposes of payment of claims, coordination of benefits, sharing information with referral providers, quality of care review studies, and fraud investigations.

I authorize Dr. Hjemboe to disclose as needed information from my health records to a provider who is working in connection with my treatment, and to appropriate accreditation and quality review personnel.I authorize my health plan(s) to disclose information as needed to Dr. Hjemboe for payment of health care benefits.

ASSIGNMENT OF BENEFITS

I agree that any Health Plan Company I have named may pay Dr. Hjemboe directly on my behalf. I accept responsibility for the fees charged by Dr. Hjemboe which are not covered by my Health Plan Company(ies). This assignment will remain in force until revoked by me in writing.

RESPONSIBILITY FOR PAYMENT

I understand and accept that is my duty to pay for any charges not covered by my insurance carrier and for which Dr. Hjemboe bills me. I know that if these bills are not paid on time they may be turned over to a collection agency. If that happens I understand and agree that I will have to pay reasonable collection and attorney's fees in addition to lawful interest and costs. I understand that I am responsible for verifying my insurance coverage for all services received and for verifying that Dr. Hjemboe is a provider under my insurance plan. If my third party payer requires me to receive a valid referral from my health care provider or HMO to get insurance coverage for those services, and if I fail to do so, I understand and accept that I must pay Dr. Hjemboe the charges for those services. I understand also that I am financially responsible for my deductible, co-payment, and charges not covered by or not paid by my insurance company. I understand that, by law, **my co-payment is due at the time of service**.

CANCELLATION POLICY

I understand that I need to give 24-hours notice when changing or canceling an appointment; otherwise, I will be charged for that appointment time. Leaving a message is sufficient to cancel an appointment. I agree to pay the **fee of $50** for a late cancelation or missed appointment.

SIGNATURE

I have read and understand the information on this form. I acknowledge that a photocopy or facsimile copy of my signature on this form shall have the same effect as an original signature. By signing this form, I give my consent to all conditions herein.

Patient's Signature:_____ **Date**:_____

Please print name: _____