# MindHealth

**ERIKA GIRALDO, DNP, ARNP / LEIF BENJESTORF, MN, ARNP**

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## REGISTRATION FORM

| Today's date: | Primary Care Name: | Primary Care Phone: ( ) |
|---|---|---|

**PATIENT INFORMATION**

| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / DP / Div / Sep / Wid |
|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Address: | Email Address: | Home phone no.: ( ) |
|---|---|---|

| City: | State: | Zip Code: | Cell Phone no.: ( ) |
|---|---|---|---|

| Occupation: | Employer: |
|---|---|

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

**INSURANCE INFORMATION**

(Please give your insurance card and drivers license to the provider.)

| Name of Primary Insured: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Please indicate primary insurance ❑ Premera ❑ Regence ❑ Value Options ❑ Group Health ❑ Cigna
❑ Aetna ❑ United ❑ Self ❑ Other:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

**IN CASE OF EMERGENCY**

| Name of friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Erika Giraldo, DNP, ARNP / Leif benjestorf, MN, ARNP or insurance company to release any information required to process my claims.

I acknowledge receipt of Financial Agreement and Notice of Privacy Practices for MindHealth.

I understand that without a 24 hour notice of cancellation, I will be billed $50 no show fee. Prescriptions outside of appointment times will be charged a $20 fee unless requests go through pharmacy.

*Patient/Guardian signature* *Date*

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