OASIS, the Center for Mental Health

Patient Registration Form

Name:	**Date:** / /
Gender: ◯ Male ◯ Female	
Ethnicity: ◯ African American ◯ American Indian/Alaska Native ◯ Asian ◯ Hispanic ◯ Native Hawaiian/Pacific Islander ◯ White	
Mailing Address:	
Sex Orientation ◯ Male ◯ Female ◯ Unspecified	Marital Status
Home Phone:	
Work Phone:	Cell Phone:
Email:	
DOB:	
Is it ok to Text? ◯ Yes ◯ No	Is it ok to email you? ◯ Yes ◯ No
Current Employer:	Occupation:
Primary Care Provider:	PCP Phone:
Referred by:	Preferred Pharmacy Name/City
Primary Insurance:	Insurance Phone:
Insurance ID#:	Group#:
Subscriber Name:	Subscriber DOB:
Subscriber SS#:	Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other:
Secondary Insurance:	Insurance Phone:
Insurance ID#:	Group#:
Subscriber Name:	Subscriber DOB:
Subscriber SS#:	Patient's Relationship to Subscriber: ◯ Self ◯ Spouse ◯ Child ◯ Other:
Emergency Contact:	**Relationship to patient:**
Emergency Contact Phone Number:	

MI

I authorize Oasis, the Center for Mental Health and independent practitioners providing services for or under Oasis to release any medical or other information necessary to process a claim and/or for continuity of care purposes.

Signed _____ Date _____/_____/_____

Patient or Authorized Person's Signature

I authorize all third party payments for services rendered to me by Oasis to be paid directly to Oasis, the Center for Mental Health.

Signed _____ Date _____/_____/_____

Patient or Authorized Person's Signature

I have been given an opportunity to review and/or receive a copy of the ***HIPAA Notice of Privacy Practices***.

Signed _____ Date _____/_____/_____

Patient or Authorized Person's Signature

I understand that I am responsible for any co-pay, coinsurance, unmet deductible amounts and/or any fees not covered by insurance at the time of my scheduled appointment. I also understand that I will be responsible for the full fee for any missed appointment as stated in our welcome letter.

Signed _____ Date _____/_____/_____

Patient or Authorized Person's Signature

RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name_____ **Patient #**_____ **Date** _____/_____/_____

Acceptance of Patient Charges Statement:

I understand that I am responsible for the fee for each session at the time of the appointment, not covered by insurance. I also understand that I will be responsible for any collection and/or legal fees incurred by Oasis to process and collect unpaid fees and charges.

Patient and or legal guardian signature:_____ Date _____/_____/_____

Contact Details:

I hereby authorize Oasis, or its designated representative, to call me at the numbers below regarding billing or appointments.
I hereby authorize Oasis to leave a message to remind me of my appointments, at the number(s) below (please provide at least two):

Home: _____ Cell: _____ Work: _____

Patient and or legal guardian signature:_____ Date _____/_____/_____

Authorization to Release Information:

I hereby authorize Oasis, or its designated representative, to release the following information:

- ☐ Billing
- ☐ Appointment
- ☐ Personal Health Information as written in my medical records

to the following persons:

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

☐ **I do not authorize any of the above information to be released to any person other than myself or legal guardian**

Patient and or legal guardian signature: _____ Date _____/_____/_____

175 Admiral Cochrane Drive, Suite 110, Annapolis, Maryland 21401
Phone: 410.571.0888, Fax: 410.571.0889
www.oasismentalhealth.net