Janice Sammons, Ph.D.

1980 E. Fort Lowell Rd. Ste. 150
Tucson, AZ 85719
Phone: (520) 296-4280 Fax: (520) 296-3835

PATIENT REGISTRATION FORM

Today's Date:_____

Note: If you are seeing the doctor regarding your child, please register your child as the patient.

Name:_____ **DOB:**_____ **Age:**_____

Address:_____
Street City State Zip

Home Phone:_____ **Work Phone:** _____ **Mobile Phone:**_____

Employer/School:_____
Name Address

SS#:_____ **Marital Status: M** _____ **S** _____ **D** _____**W** _____

Referred By:_____ **Family Physician:**_____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Responsible Party:_____ **Relationship to patient:**_____

Address:_____
Street City State Zip

Home Phone:_____ **Work Phone:**_____**Mobile Phone:**_____

Employer:_____
Name Address

SS#:_____ **Marital Status: M**_____ **S**_____ **D**_____ **W**_____

Insurance Name:_____ **ID#**_____

IF YOU HAVE INSURANCE WE ARE FILING FOR YOU PLEASE PROVIDE IT TO US

PLEASE READ & SIGN THE OTHER SIDE

Janice Sammons, Ph.D.

1980 E. Fort Lowell Rd. Ste. 150
Tucson, AZ 85719
Phone: (520) 296-4280 Fax: (520) 296-3835

PRACTICE POLICIES

- Payment is expected at each visit unless other arrangements are made with Janice Sammons, Ph.D.

- There will be a charge for missed appointments, appointments cancelled with less than 24 hours notice, report preparation, and extended phone calls. Please ask if you have questions about this.

- Each therapist/doctor at 1980 E. Fort Lowell Road, Suite 150 has a separate practice. This is not a group practice or partnership. Please be aware that there exists only an office sharing arrangement and that no partnership exists. Dr. Sammons' clinical practice is fully independent.

- **We do not file or bill insurance**. Your insurance coverage is a contract between you and your insurance carrier. You are responsible for all charges incurred. We provide a superbill to assist you in your filing for any available reimbursement with your insurance company.

- I hereby authorize the release of any and all information necessary for Janice Sammons, Ph.D. to provide or coordinate care on my behalf. This release of information will remain in effect until revoked by me in writing. A photocopy of this release is to be considered as a valid original. I understand that I am responsible for all charges whether or not authorized and paid by my insurance. If the patient is a dependent or minor I/we agree to be responsible for all clinical charges incurred by the patient.

- In certain cases Dr. Sammons will receive email communication from patients but she **does not** respond to email.

- If the patient is a minor, by signing below you are affirming that you are the parent or legal guardian and you have the authority to consent to professional services.

- I have read, understand, and agree to these polices. I have also read and agree to Dr. Sammons' practice information brochure detailing office policies.

_____ _____

Signature of Patient Signature of Responsible Person

_____

Relationship to Patient

_____ _____

Date Date