New Patient Registration Form (*Please print*)

Last Name: ______________________________ First: ______________________ M: _____

Date of Birth: _______________ Age: ______ Social Security: ___________________________

Street Address: ____

City: __________________________________ State: _____________ Zip Code: _________

Home Phone: _________________ Mobile: ___________________ Work: ________________

Referred By: _______________________________ Employer: _________________________

Person to Notify in Emergency: _____________________________ Phone: ________________

Marital Status: ________ Primary Language: ________ Race: ___________ Ethnicity: __________

Financial Responsibility

Last Name:______________________________ First: ______________________ M: _____

Date of Birth: __________ Social Security: ___________ Relationship to Patient: _______________

Street Address: ____

City: _____________________________ State: ___________ Zip Code: _________________

Primary Insurance Information

Name of Insurance Company: ________________________ ID#: ____________________________

Subscriber Name: ________________ Subscriber DOB: ________ Group#: ______________________

Subscriber's Employer: ______________________ Relationship to Patient: __________________

Secondary Insurance Information

Name of Insurance Company: ________________________ ID#: ____________________________

Subscriber Name: ________________ Subscriber DOB: ________ Relationship to Patient: ____________

MONTES
PSYCHIATRIC CENTER, P.C.

6090 Strathmoor Dr.
Suite 1
Rockford, IL 61107

Phone: 815.839.8180
Fax: 815.839.8290
www.montespc.com

Montes Psychiatric Center P.C. Missed Appointment Policy

Dear Client,

We would like to take this opportunity to welcome you to Montes Psychiatric Center, P.C., and to thank you for choosing our providers to participate in your mental health. We look forward to providing you with personalized, comprehensive mental health care focusing on wellness and prevention.

Our staff will dedicate their time to your clinical appointments. Part of your recovery depends on you taking responsibility to keep those appointments. If you have other important commitments that make it impossible for you to keep your scheduled appointment, we expect you to call and cancel your appointment at least 24 hours in advance. Your accountability starts when you make a commitment to change and get involved in treatment. We do not want to enable you by encouraging your lack of response in regard to our time and commitment to your treatment.

IF YOU MISS YOUR APPOINTMENT WITHOUT PROPER NOTIFICATION, YOU WILL BE ASSESSED A $50.00 MINIMUM FEE!

If you feel you had a valid reason for missing your appointment, you should contact our office as soon as possible to provide the reason for your missed appointment and may be rescheduled after you have paid the "No Show" fee of $50.00, or $50 per hour for psychological testing.

If you do not show for your appointment a second time, you may be permanently discharged from the Montes Psychiatric Center, P.C., no exceptions.

I, ________________________(Patient Name/Parent or Guardian) on _______(Date) have read and understand the terms of this document and agree that they will apply to my treatment at Montes Psychiatric Center, P.C.

____

Signature of Patient or Legal Guardian Date

MONTES
PSYCHIATRIC CENTER, P.C.

6090 Strathmoor Dr.
Suite 1
Rockford, IL 61107

Phone: 815.839.8180
Fax: 815.839.8290
www.montespc.com