Smith Behavioral Health
4925 Greenville Ave Suite 200
Dallas, Texas 75206

REGISTRATION FORM					
Last name: First:		☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
E-mail address:	Cell Phone No:		Birth date:	Age:	Sex: ☐ M ☐ F
Street address:	Apartment No.:		Home Phone No.:		
P.O. Box:	City:		State:	ZIP Code + 4:	
Emergency Contact Name:	Cell Phone No:				

PATIENT'S RIGHTS & RESPONSIBILITIES
(Please initial each paragraph below to indicate that you have read and understand the office policies and agree to abide by them)

_____APPOINTMENT CANCELLATION POLICY: SBH requires that cancellations for scheduled appointments be received 24 "business" hours in advance during regular office hours. If this does not happen, the patient will be charged the contracted amount that his/her insurance company pays the clinician. Private pay patients will be charged $150 for late cancellations or missed appointments.

_____INSURANCE BILLING: Smith Behavioral Health (SBH) does bill insurance. Co-payments, if applicable, are to be paid when services are rendered. I also authorize Smith Behavioral Health or insurance company to release any information required to process my claims.

_____PAYMENT POLICY: SBH requires payment for services at the time they are rendered. Payments may be made by cash, personal check, or credit card.

By signing below, I give consent for services and I acknowledge reading and understanding patient's rights and responsibilities and the above stated policies of Smith Behavioral Health.

Patient's Signature: _____ Date: _____