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REGISTRATION FORM

Name ____ DOB ________________

Address ____ City ____________________

State _________ Zip _____________ Email ______________________________________

Phone Numbers: (Home) _______________________ (Work)___________________________

(Cell) ___________________________ (Please note preferred number(s) for contact)

Emergency Contact Information: Name ____

Relationship to you _______________________ Phone Number ______________________

Name of Parent or Guardian (for minors) ____

Address/Phone of Parent or Guardian ____

Insurance Name _________________________ ID# _________________________________

Subscriber's Name ______________________________ Relationship to you ______________

Primary Care Physician Name, City, and Phone_____________________________________

How did you hear about my practice? ____

I understand I am responsible for adhering to my insurance company's policies regarding authorization and payments for services rendered at Pathways Psychology, PLLC. I request that payment of authorized insurance benefits be made on my behalf to Pathways Psychology, PLLC for any services furnished me by Pathways Psychology, PLLC.

Signature ____ Date ____________________

Medicare Patients: I request that payment of authorized Medicare benefits be made on my behalf to Pathways Psychology, PLLC for any services furnished me by Pathways Psychology, PLLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service.

Signature ____ Date ____________________

Revised August 2018