Phone 617 291- 6470 suzannebrooks@gmail.com 60 Oak Knoll Terrace Needham, MA 02492

Fax 781 433-2691 www.DrSuzanneBrooks.com Needham, MA 02492

PATIENT REGISTRATION

TODAY'S DATE: _____ DATE OF BIRTH: _____

PATIENT'S NAME: _____ SEX: M F STUDENT?: YES NO

ADDRESS: _____ TEL. (home) _____

CITY: _____ STATE & ZIP: _____

MAILING ADDRESS (if different):_____ _____

RESPONSIBLE PARTY: (who is responsible for payment of all costs incurred)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ TEL. (Home): _____

CITY: _____ TEL. (Cell): _____

STATE & ZIP: _____ TEL. (Work) _____

PATIENT'S RELATIONSHIP: SELF SPOUSE CHILD OTHER SS# _____

E-MAIL ADDRESS:_____

PRIMARY INSURANCE CO. _____ INS. ID NO. _____

INSURANCE PHONE NO.: _____ GROUP NO. _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SUBSCRIBER'S ADDRESS: _____

CITY: _____ STATE & ZIP: _____

SUBSCRIBER EMPLOYER: _____ EMPLOYER TEL.: _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

SECONDARY INSURANCE CO. _____ INS ID NO. _____

INSURANCE PHONE NO.: _____ GROUP NO. _____

SUBSCRIBER NAME: _____ DATE OF BIRTH: _____

SUBSCRIBER'S ADDRESS: _____

CITY: _____ STATE & ZIP: _____

SUBSCRIBER EMPLOYER: _____ EMPLOYER TEL.: _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER
_____-
THIRD PARTY INFORMATION:
WERE YOU INJURED WHILE WORKING? (Workers' Comp) NO YES ☾ Date of Injury:
_____/_____/_____
WORKER'S COMP. INS. CO.: _____ CLAIM ID NO:
_____
INSURANCE PHONE NO:_____ ADJUSTER'S NAME:
_____
MOTOR VEHICLE ACCIDENT? NO YES ☾ STATE:_____ Date of Accident _____/_____/_____
AUTO INSURANCE COMPANY: _____ CLAIM ID NO:
_____
INSURANCE PHONE NO: _____ ADJUSTER'S NAME:
_____
OTHER ACCIDENT NO YES ☾ Date of Injury: _____/_____/_____
ARE YOU REPRESENTED BY AN ATTORNEY? NO YES ☾
ATTORNEY'S NAME: _____ PHONE NO:
_____
ADDRESS:
_____
_____

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the “Responsible Party") promises to pay to Suzanne Brooks, Psy.D. all charges incurred for services rendered to the patient. The Responsible Party understands that Dr. Brooks will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible
Party, and the Responsible Party authorizes Dr. Brooks to release any and all medical information necessary to complete insurance
claim(s) and assigns any monies due and owing under the insurance contract to Dr. Brooks. It is, however, understood and
agreed that the Responsible Party is responsible for all monies due and owing for services rendered by Dr. Brooks in the
event insurance does not pay for these services. It is acknowledged that the ultimate completing and following-up of any
insurance claims is the responsibility of the Responsible Party and agrees that accounts that are not paid within (60) days
will accrue interest at the rate of 1.5% per month (18% A.P.R. - a minimum of $1.00 will apply). In the event this
account is turned over to an attorney and/or collection agency for collection, the Responsible Party hereby agrees to pay all
costs of collection including, but not limited to, court costs and attorney's fees. The Responsible Party authorizes use of this
form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party
agrees to be bound by the terms and conditions of this account with Dr. Brooks.
SIGNATURE: _____ DATE:
_____
PRINTED NAME: _____
LATE CANCELLATION POLICY ON THERAPY/FEEDBACK APPOINTMENTS : A minimum of 24 hours' notice
is required for cancellation of appointments. If this notice is not received, the Responsible Party will be charged for the full
amount of time which was reserved for the appointment at the rates posted in the office of Dr. Brooks.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

Suzanne Brooks, Psy.D.