KEVIN LEEHEY, M.D.

Child, Adolescent, and Adult Psychiatry, APBN Board Certified

www.leeheymd.com

1980 E. Fort Lowell Rd. Suite 150
Tucson, AZ 85719

Phone (520) 296-4280
Fax (520) 296-3835

PATIENT REGISTRATION FORM

(Please Print Clearly)

Legal Name:_____DATE: _____

Preferred Name:_____DOB (birth date):_____

SSN: _____ Email Address: _____

Address:_____
(Number, Street, Box, Apt, Space) (City) (State) (Zip)

Cell Phone:_____Home Phone:_____Work/Other Phone:_____

Emergency Contact (name and phone)_____

Employer/ School :_____
(Name) (Address)

Referred By:_____Family Physician_____

Current Medication(s):_____

Preferred Pharmacy:_____
(Name, Phone Number & Cross Streets)

RESPONSIBLE PARTY:

NAME:_____

DOB:_____ Relationship to patient_____ SSN: _____

Address:_____
(Number, Street, Box, Apt, Space)

Cell Phone:_____ Home Phone_____Work/Other Phone:_____

Noncustodial Parent, if any:_____
(Name) (Address)

Cell Phone:_____Home Phone:_____Work/Other Phone:_____

WE DO NOT FILE OR BILL INSURANCE.

PLEASE READ AND SIGN OTHER SIDE (Page 2)

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FINANCIAL POLICIES

- Payment is due and expected at the time of service. Personal checks, cash, and Visa/MasterCard are accepted. There is a $25 charge for returned checks.

- There is a charge for appointments missed, changed or canceled with less than 24 working hours notice.

- Due to the extra time and case review needed, there is a charge for extended or complex phone calls, and for letters, reports, or authorizations done on your behalf for other clinicians or insurance companies or at your request.

- Delinquent accounts will be subject to a 1.5% interest charge per month. I further agree, that should my account be turned over to a collection agent, I will be responsible for any and all changes incurred as a result of the collection process. If temporary financial problems arise, please contact office billing staff so that an adequate payment plan may be arranged.

- 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. Leehey's clinical practice is fully independent of all persons, agencies, and he is a sole proprietor.

- 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 Dr. Leehey 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 valid as the 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.

- HIPPA is a federal law governing internet related billing transactions. HIPAA is intended to improve such electronic transactions and enhance privacy. Dr. Leehey's practice meets or exceeds HIPAA privacy standards.

- I have read, understand, and agree to this sheet of policies. I have also read and agree to Dr. Leehey's practice information brochure detailing office policies.

Signature **Date**