TRUENORTH PSYCHIATRIC NURSING CORP

863 Bowsprit Road, Ste 174 | Chula Vista, CA 91914

Phone: 619-614-8009 | Email: maja.ceranic.nusn@gmail.com

New Patient Registration Form

Please complete this form accurately. Information is used to establish your record, coordinate care, verify benefits when applicable, and communicate with you regarding treatment.

Date: _____ Preferred appointment: ☐ Telehealth ☐ In-person, if available

PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____ Date of Birth: _____ Pronouns: _____

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to answer Gender identity: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Mobile Phone: _____ Alternate Phone: _____

Email Address: _____

Preferred contact: ☐ Phone ☐ Text ☐ Email ☐ Patient Portal Leave voicemail? ☐ Yes ☐ No

Text messages for appointments/administrative matters? ☐ Yes ☐ No

EMPLOYMENT / SCHOOL

Current status: ☐ Full-time ☐ Part-time ☐ Student ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Other _____

Employer / School: _____ Occupation: _____

INSURANCE & PAYMENT INFORMATION

☐ I will be using insurance. ☐ I am a self-pay patient.

Primary Insurance

Insurance Company: _____ Member / Policy ID: _____

Group Number: _____ Policyholder Name: _____

Relationship: ☐ Self ☐ Parent/Guardian ☐ Spouse/Partner ☐ Other _____ DOB: _____

Policyholder Address (if different): _____

PRIMARY CARE & OTHER HEALTHCARE PROVIDERS

Primary Care Provider: _____ Practice / Organization: _____

Phone: _____ Fax: _____

Other Psychiatrist / MH Provider: _____ Phone: _____

Therapist / Counselor: _____ Phone: _____

Other Specialist(s): _____

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NEW PATIENT REGISTRATION

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____ City / State: _____

REFERRAL INFORMATION

How did you hear about TrueNorth?

☐ Healthcare provider ☐ Therapist/Counselor ☐ Insurance directory ☐ Psychology Today

☐ Internet/Search Engine ☐ Friend or Family ☐ Social Media ☐ Other _____

Referring provider/person (if applicable): _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Alternate Phone: _____

Providing an emergency contact does not automatically authorize routine disclosure of protected health information. Information may be disclosed as permitted or required by applicable law, including certain emergency or safety circumstances.

PERSON FINANCIALLY RESPONSIBLE FOR SERVICES

Complete only if different from the patient.

Name: _____ Relationship: _____ Phone: _____

Email: _____ Billing Address: _____

City: _____ State: _____ ZIP: _____

INSURANCE AUTHORIZATION & FINANCIAL RESPONSIBILITY

If I elect to use insurance benefits, I authorize TrueNorth and its healthcare providers to submit claims to my health plan for covered services provided to me and authorize payment of applicable insurance benefits directly to TrueNorth when permitted by my health plan and applicable law.

I authorize TrueNorth to disclose information reasonably necessary for treatment, healthcare operations, insurance eligibility verification, claims processing, utilization review, and payment as permitted by applicable law.

I understand that verification of insurance benefits is not a guarantee of coverage or payment. I am responsible for applicable deductibles, copayments, coinsurance, non-covered services, and other patient-responsibility amounts consistent with my health plan, TrueNorth's financial policies, and applicable law.

If I choose self-pay services, I understand that I am responsible for charges in accordance with the financial agreement. Additional policies regarding fees, cancellations, missed appointments, billing, refunds, and related matters may be addressed in TrueNorth's separate Financial Policy.

PATIENT ACKNOWLEDGMENT

I certify that the information provided on this form is accurate and complete to the best of my knowledge and agree to notify TrueNorth of changes to my contact information, insurance, pharmacy, emergency contact, or other relevant information.

I understand that this registration form does not replace separate informed-consent documents or practice policies that may apply to my care, including telehealth consent, privacy practices, medication policies, and other clinical or administrative agreements.

Patient Name: _____ Date: _____

Patient / Legal Representative Signature: _____

Type full legal name as electronic signature if completing electronically.

If signed by someone other than patient - Printed Name: _____

Relationship / Legal Authority: _____