Pacific Northwest Recovery & Counseling
TMS Oregon
Liana Hategan MD PC

New Patient Questionnaire / Registration

Name ______________________________ Social Security # _____-____-_____ DOB _____________

Address _______________________________ Apt ____ City ______________ State ____Zip _______

Phone ___________________ Cell ____________________

Email____

How did you hear about us? ____

Employer ____ Phone ______________________________

Employer Address____ Occupation _______________________

Marital Status Single ____ Married ____ Divorced ____ Separated ____ Partnership ____

Spouse/Parent _________________________________ DOB _________ Phone ____________________

Address (if different)

____

Employer ____ Phone ____________________

Emergency Contact ____ Phone ____________________
(relative other than spouse)

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Insurance Information

Insurance Company _______________________________ Policy Number _______________________

Plan Name _______________________________________ Group Number _______________________

Policyholder's Name ____ DOB_________

Relationship to Insured Self - Spouse - Child - Other

Is your condition the result of a work injury? YES NO An auto accident? YES NO

Date of injury __________

Medical Information

On Disability? Yes No How long? ________________________

Psychiatric Hospitalization? ___________________ Rehab?____________________________

Suicide attempts? ____________________ Suicidal Ideation? ____________________

If you know someone is having a psychiatric emergency please call 911.

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Diagnosis______________________________

Symptoms

Medications

Therapist?___________________________ **PCP** ___________________________

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Other Important Information

New Patient Questionnaire completed by ______________________________________

Signature ____ **Date** ______________

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Fees and Payment Policy

Fees and Payments - Liana Hategan MD PC is a fee-for-services practice. Payment is due at the time of service for all charges unless you elect to have us bill your insurance.

Insurance Billing - I hereby give authorization for payment of insurance benefits to be made directly to Liana Hategan, MD PC and any assisting service provider for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Returned Checks - A fee of $30.00 will be charged for returned (NSF) checks.

Past Due Balances – Balances over 30 days past due are subject to a finance charge of 9% per annum. Treatment may be suspended for patients with balances past due of over 60 days. Balances over 90 days past due may be referred to a collection agency.

A $100 deposit is required when scheduling your first appointment. The deposit will go towards copays and costs accrued due to services rendered. If a cancellation is necessary, that must be done 24-hours in advance of your appointment in order to receive the refunded deposit.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees. My signature serves as verification of understanding of and consent to these policies.

Acknowledges $100 deposit? Yes No

Patient Print Name____

Relationship to Patient ____

Signature_______________________________________ **Date**______________

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