Anne Huebner & Associates
Phone: 262-786-9184 262-786-4665
17100 W. North Ave., Ste. 100 Brookfield, WI 53005
Fax: 262-786-1906

REGISTRATION FORM

Patient Information Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip _____

Phone _____ Work Phone _____ _____ Cell Phone _____

The best time to contact me is: ☐ A.M. ☐ P.M. On my ☐ Home phone ☐ Work phone ☐ Cell phone

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If Student, Name of School _____ City/State _____

Spouse or Parent's Name: _____ Employer _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Email Address _____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information

Name of Insured _____ DOB _____ Relationship to Patient _____

Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City _____ State: _____ Zip _____

INSURANCE COMPANY _____ **ID #** _____ Group# _____

DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ DOB _____ Relationship to Patient _____

Name of Employer: _____ Work Phone: ____ _____

Address of Employer: _____ City _____ State: _____ Zip _____

Insurance Company _____ ID # _____ Group# _____

ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF ACCOUNT

I hereby authorize payment directly to *Anne Huebner, Ph. D.*, and the providing staff, of benefits otherwise payable to me, including major medical insurance, agreeing that said assignment is irrevocable. I also authorize refund to the insurance company or healthcare payer of overpaid benefits where my coverages are subject to coordination of benefits. I authorize any overpayment due me on this account to be first applied to any other unpaid balance I may have with *Anne Huebner, Ph. D.* I understand that I am ultimately responsible to *Dr. Huebner* for payment of all charges incurred. I agree to pay my account, when due, in accordance with *Dr. Huebner's* policy covering that payment of outstanding balances due.

Signature _____

CERTIFICATION AND AUTHORIZATION FOR MEDICARE CLIENTS (ALL CLIENTS WITH *MEDICARE* MUST SIGN)

I request payment of authorized *Medicare* benefits be made on my behalf for any services furnished to me by or in *Dr. Anne Huebner's* office, including physician/psychological services. I authorize any holder of medical and other information about me to be released to *Medicare* and its agents any information needed to determine these benefits for related services. I permit a copy of this authorization to be used in place of the original.

Signature _____