Steven D. Nichols, Ph.D., LLC
Licensed Psychologist
3200 Linwood Avenue, Suite 2
Cincinnati, OH 45226
513-312-2203

Date: ____________________

PATIENT REGISTRATION INFORMATION

(Please Print)

Name: ____ __________________________
Last Name First Name M.I. Is There A Preferred Name?

Address: ________________________________ City: _________________ State: _____ Zip: __________

Date of Birth: __________________________

Phone: _________________(cell) _________________ (home) OKAY TO LEAVE VOICEMAIL? ___________

Are you?: ______ Female ______ Male ______ Transgender (AFAB) ______ Transgender (AMAB)

Marital Status: ____Single ____Married ____Partnered ____Widowed ____Separated ____Divorced

Patient Employed By: _____________________________________ Occupation: ___________________

Business Address: ____ Work Phone: _______________

Who may I thank for referring you? ___________________________________

In case of emergency, who should be notified? ___________________________ Phone: _____________

PRIMARY INSURANCE

Name of Insurance Company: _______________________ Subscriber/Member ID#: _____________________

Insurance Group #: ____________________________________

If your insurance is not solely under your name as the primary insured, please tell me the subscriber name/person responsible for the insurance policy you're using:

____ Relationship to Patient: __________________
Last Name First Name M. I.

Home Address of Subscriber/Person Responsible for Account:
(complete only if different from patient): ___________________________________City: _________________

State: __________ Zip: ______________ Date of Birth of Subscriber: _______________________

Subscriber Employed By: _____________________________________

SECONDARY INSURANCE

Is patient covered by a secondary insurance? _____ YES _____NO

Name of Insurance Company: _______________________ Subscriber/Member ID#: _____________________

Insurance Group #: ____________________________________

If your secondary insurance is not solely under your name as the primary insured, please tell me the subscriber name/person responsible for the insurance policy you're using:

____ Relationship to Patient: __________________
Last Name First Name M. I.

Home Address of Subscriber/Person Responsible for Account:
(complete only if different from patient): ___________________________________City: _________________

State: __________ Zip: ______________ Date of Birth of Subscriber: _______________________

Subscriber Employed By: _____________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance with____,
(insert name of insurance company/companies here)

and assign directly to Steven D. Nichols, Ph.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I also hereby authorize Steven D. Nichols, Ph.D. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ___________________________
Responsible Party Signature (Parent Signature if minor patient) Date Signed