CONFIDENTIAL

Bradley J. Shaw, CRNP, FNP-C, PMHNP-BC
1229 S. 2nd St, Ste. B, Clearfield, PA 16830
Phone: 814-762-4890 Fax: 814-240-6632

Patient Registration Information

Last Name: _____First Name: _____Middle Initial: _____

Preferred Name or Nickname: _____ DOB: _____ /_____/_____ Gender: M ___ F ___ Other ___

Address:_____City:_____State:_____Zip:_____

Mailing Address (Physical address only, no PO Boxes): _____

Primary Phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Work phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Place of Employment: _____ Please circle one: Full time Part time

Email: _____

Primary Care Provider: _____ Phone:_____

Who were you referred by?: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Emergency Contact Relation: _____

Billing Address: Check if same as above ( )

Last Name: _____First Name: _____Middle Initial: ____

Relationship to patient: _____

DOB _____ Driver's License _____State_____

Address:_____City_____State_____Zip_____

Mailing Address (if different from above) _____ City_____ State_____ Zip_____

Primary Phone: _____ Message Ok? Yes / No Secondary Phone: _____

I acknowledge that I have received a copy of Still Waters Mental Health Services Privacy Practices
Patient name or guardian/parent: _____ Date: _____

Bradley J. Shaw, CRNP, FNP-C, PMHNP-BC
1229 S. 2nd St, Ste. B, Clearfield, PA 16830
Phone: 814-762-4890 Fax: 814-240-6632

CONFIDENTIAL

Insurance information:

Please bring your insurance card(s) and ID to your first appointment. The primary insurance is usually based on the earliest birthday of the subscribers.

Primary Insurance: _____

Customer Service Phone Number: _____

Place of Employment: _____

Main Subscriber/Member Name (if other than patient): _____ DOB: _____

Subscriber ID # _____ Group /Policy # _____

Relationship To Patient/Patient: _____

Please check with your insurance company to find out your benefits and responsibilities, including if you have a deductible and the amount of your co-pay.
Please be prepared to pay your co-pay and deductible (if applicable) at the time of the visit. We accept cash, checks, all major credit cards, and HSA/FSA cards.

Deductible (if applicable) _____ New Deductible begins _____

Co-pay or Co-insurance_____

I authorize Still Waters Mental Health Services, LLC to bill my insurance company as well as release any information needed to do so and assign benefits to Still Waters Mental Health Services, LLC.

Printed Name: _____ Signature: _____ Date: _____

Responsible party (If Under 18): _____