Tele-Behavioral Medicine Assoc.

Herbert A. Schwager, Ph.D.
DABMP, CCTP, DABDA
Cell: (907) 715-7391
Fax: (907) 495-1283
http://telebehavioralmedicine.com
tbma@mtaonline.com

Office Phone (907) 782-4873 Office Fax (907) 312-5551
PO Box 522, Willow, AK, 99688 - Office Cell 907-203-7187

Behavioral Medicine - Pain Management - Telemedicine Consultation and Program Development - Clinical Pharmacology

Patient Demographic/Registration

Date: _____ Patient Name: _____

DOB: _____ ☐Male ☐ Female SSN#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: ☐
Check if Same as Physical _____

City: _____ State _____ Zip: _____

Email Address: _____ Zoom Username: _____

Employer: _____ Employer Phone: _____

Referring Provider: _____ PCP: _____

Insurance Carrier: _____ Insurance Phone: _____

Insurance Address: _____

Insurance ID: _____ Group #: _____

Subscribers Name: _____ Subscribers DOB: _____

Relationship to patient: _____

Is this a work-related injury? ☐ Yes ☐ No If so, please list date of injury: _____

Current Adjuster Name: _____ Adjuster Phone: _____

Is this a MVA related injury? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____
(Cell) (Work) (Other)

_____ _____
Patient Signature Date

Tele-Behavioral Medicine Assoc.

Herbert A. Schwager, Ph.D.
DABMP, CCTP, DABDA
Cell: (907) 715-7391
Fax: (907) 495-1283
http://telebehavioralmedicine.com
tbma@mtaonline.com

Office Phone (907) 782-4873 Office Fax (907) 312-5551
PO Box 522, Willow, AK, 99688 - Office Cell 907-203-7187

Behavioral Medicine - Pain Management - Telemedicine Consultation and Program Development - Clinical Pharmacology

FINANCIAL RESPONSIBILITY – Please read carefully

PAYMENT POLICY: If you would like us to bill your insurance we will be happy to do so. Please note that since we are not contracted with any insurance company, it may be their policy not to reimburse non-contracted providers. However, the ultimate responsibility for payment of your account remains solely with you, the patent. Your signature below gives us permission to contact your insurance carrier or other health care professionals treating you for assistance in billing only.

CANCELLATION POLICY: We want you to keep your appointments because we believe it is in your best interest to receive this level of care. We require a 24-hour notice if you will be unable to keep your appointment. If you do not cancel your appointment within 24 hours you will be charged $25.00.

Fees: Negotiated at time of service, Insurance will be billed when appropriate. Fees remain my ultimate responsibility

I HAVE READ AND UNDERSTAND MY RESPONSIBILITIES.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date