Plymouth Psych Group

Welcome to Plymouth Psych Group!

Thank you for scheduling an appointment with us. We look forward to working with you!

Please review, complete and bring the following forms to your appointment:

1.) Registration
2.) Patient History
3.) Release of Information
4.) Practice Policies
5.) Informed Consent
6.) Current Insurance Card

- **All forms can be found at www.plymouthpsychgroup.com under the "Forms" tab.**
- **Forms may also be mailed, emailed or faxed to your home upon request.**
- **If you are unable to print and complete the forms prior to your appointment, please plan to arrive 20 minutes prior.**

Release of Information: Use this form if there are records (from a previous therapist/counselor, primary care provider, school, hospital, etc.) that would be important for your provider to view. Please select "Most Recent Evaluation + Last 3 Progress Notes" and any other information your provider may need on the form.

Underage Patients: If a child is the focus of the appointment, please have them complete the child portion of the Patient History Form in order for your provider to get a clear idea of the patient's current situation.

First Appointment Cancellations/No-Show Policy

All new patient appointments must be cancelled within 48 hours of the appointment time to avoid being unable to schedule future appointments at the clinic.

Plymouth Psych Group

Main Clinic:
3021 Harbor Lane N, Suite 206 • Plymouth, MN 55447
Phone: 763-559-1640 • Fax: 763-559-1617
info@plymouthpsychgroup.com

Specialty Programs:
3021 Harbor Lane N, Suite 105 • Plymouth, MN 55447
Phone: 952-444-2099 • Fax: 763-559-1617
specialtyprograms@plymouthpsychgroup.com

www.plymouthpsychgroup.com

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REGISTRATION FORM

Part A: Patient Information

Today's Date: _____/_____/_____

Name (Last, First, M.I.):	Date of Birth:
Sex:	Marital Status:
Occupation:	Employer:
Language:	Race/Ethnicity:
Address 1:	Phone:
Address 2:	Email:
City, State, Zip:	SSN:

Part B: Guarantor Information *(financial responsibility; if different from above)*

Name (Last, First, M.I.):	Date of Birth:
Address 1:	SSN:
Address 2:	Occupation:
City, State, Zip:	Employer:

Part C: Insurance Information *(please provide insurance card)*

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
Subscriber SSN:	Subscriber SSN:
Subscriber DOB:	Subscriber DOB:
Policy #:	Policy #:
Group #:	Group #:
Copay:	Copay:
Relationshp to Patient:	Relationshp to Patient:

Part D: Emergency Contact Information

Contact Name:	Relationship to Patient:
Phone 1:	Phone 2:

Part E: Referral Information

How Did You Hear About Us? ☐ Google Search ☐ Print or Online Ad ☐ Friend or Family Member
☐ Referred by Physician/Clinic/School: _____Other: _____

Signature: _____ **Date:** _____

Payment for co-payments, deductibles and coinsurance are expected at the time of services rendered. Any necessary financial arrangements should be made prior to treatment. We bill only insurances we are contracted with. The above information is accurate to the best of my knowledge.

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