# *Dr. Sandra Rahe, LIMHP*

***Phone: 402.299.3018 www.DrSandraRahe.com***

***16707 Q Street, Suite 2 Omaha, Nebraska 68135-1248***

## Registration Information

**PERSONAL INFORMATION:** (Complete on behalf of the patient)

**Name**: _____ **DOB**:_____
First Middle Last

Street Address: _____Email:_____

City: _____ State: _____ Zip: _____

**Social Security #:**_____ **Sex**: Male ☐ Female ☐

Home Phone: _____Work Phone: _____Cell:_____
**OK** to call? Y ◉ N ○ **OK** to call? Y ◉ N ○ **OK** to call? Y ◉ N ○

**Employer** _____ Occupation: _____

**Marital Status** (circle): Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐

**Spouse**: _____Work Phone: _____Cell: _____
**OK** to call? Y ◉ N ○ **OK** to call? Y ◉ N ○

**Spouse's Employer:** _____Occupation: _____

*****How did you hear about me?*** _____

**PERSON(s) RESPONSIBLE FOR THIS ACCOUNT**:

Name: _____DOB: _____ Phone: _____

Address: _____Email:_____

**EMERGENCY CONTACT**:_____Phone:_____

**Physician**: _____Phone:_____

Psychiatric Advanced Directive: I do____do not____have an Advance Directive or Power of Attorney for Health Care. It's a legal document explaining how you want to be treated if you become incompetent & can't decide yourself**.**

**Primary** Insurance (Name & Address)**:** _____

Policy Holder: _____ DOB: _____

ID#: _____ Group#: _____ Employer**:** _____

**Secondary** Insurance (Name & address): _____

Name of Subscriber:_____ DOB: _____

ID#: _____ Group#:_____Employer:_____

**I have contacted or will contact my Insurance Company to verify my Mental Health Benefits. I understand this is my responsibility.**

***Signature*:**

ASSIGNMENT OF INSURANCE BENEFITS:

☐ I hereby authorize **Dr. Sandra Rahe, LIMHP** to release information necessary to process insurance claims relating to my treatment.

☐ I authorize my insurance company to directly pay **Dr. Sandra Rahe, LIMHP** all benefits on my behalf.

☐ **I will be responsible for all expenses related to treatment not paid under this plan(s*).***

Client signature: _____ Date: _____

Guardian (if a minor)_____ Witness_____