Nicole Ann Cavenagh, PhD
Licensed Psychologist/Pediatric Neuropsychologist

REGISTRATION FORM

Date	New Patient or Established Patient			SS #
Patient Name: Last	First			MI
Home Phone	Sex	D.O.B.	Age	Parent Marital Status: (circle one) Married Divorced Widowed Separated Single
Mobile Phone	Other Phone		E-mail	
Address				Apt/Space/Unit
City	State			Zip
Parent/Legal Guardian Name:	Parent/Legal Guardian Name:			Patient's School:
Person Responsible for Account's Employer			Occupation	
Employer's Address				Work Phone
City	State			Zip
Emergency Contact: Name	Relationship			Phone Number
Primary Insurance: Group #	Member #			Name of Primary Holder
Primary Holder DOB	Relationship to Patient			Insurance Company Phone #
Secondary Insurance: Group #	Member #			Name of Secondary Holder
Secondary Holder DOB	Relationship to Patient			Insurance Company Phone #

169 W 2710 S Circle, Suite 201-C, St. George, UT 84790 P: (435) 288.1432 F: (435) 652.0647

The information on the Registration Form is complete and correct. I understand that I am financially responsible for all charges and that Nicole Ann Cavenagh, PhD, is not paneled with any insurance providers in the state of Utah. Further, I understand that Nicole Ann Cavenagh, PhD, does not submit bills to insurance companies for out-of-network benefits. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to the collection services fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Nicole Ann Cavenagh, PhD, as may be dictated by prudent medical practice by my condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

_____ _____

Signature of Patient, Parent, or Guardian **Date**

_____ _____

Printed Name of Patient, Parent, or Guardian **Relationship to Patient**