Registration Form
Amita Jha MD LLC

Patient Information Date_____

Name _____ Age _____ Birth Date_____

SS# _____ Marital Status _____ Occupation _____

Employer _____ Work Phone _____ Cell _____

Address _____ City _____

State _____ Zip _____ Home Phone _____

Referred By _____ Phone _____

Can we Contact them Yes No Signature _____

Emergency Contact _____ Relationship _____

Phone _____

Insurance Information

Person Responsible for Account _____ Phone _____

Relationship to Patient _____ SS# _____

Primary Insurance Company _____ ID# _____

Group# _____ Phone _____

Secondary Insurance _____ ID# _____

Agreement to Treatment

I agree to be treated by Dr. Amita Jha MD. I understand that I may be treated with medications and psychotherapy and sometimes these can have side-effects or may not work as well for all the symptoms. I understand medications may sometimes be used for off label indications in order to alleviate my symptoms. I understand that if l have any other questions or wish to know more, I can request further information and also that I can refuse any treatment/ medications if not satisfied with the information.

Assignment of Benefits (for patients using insurance only)

l hereby authorize Dr. Amita Jha MD to apply on my behalf for covered services rendered. The payment from the Insurance company may directly be made to Dr. Jha. I authorize Dr. Jha to release medical information needed for the processing of payments.

Signature _____ Date _____