DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC
Beth Chadwick, PMHNP-BC

Patient Registration Form

Patient Full Name:_____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Phone:_____ Email_____

Date of Birth _____ Gender:_____

Marital Status:_____ Referred By:_____

Health Insurance Information

Carrier Name: _____

Insurance ID#_____ Group #:_____

Referral # (Tufts Only):_____

Subscriber Name:_____

Subscriber Relationship To Patient:_____

Subscriber Date of Birth: _____ Subscriber Employer:_____

Please take a picture of your health insurance card on your mobile device and send it to us as an attachment in the secure messaging area of the portal.

175 Derby Street Suite 7 Hingham, MA 02043 | 781-749-2278

DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC
Beth Chadwick, PMHNP-BC

Informed Consent For Treatment

I, _____ agree and consent to participate in psychiatric services provided by Deborah Farber, APRN, Lauren Wilson, PMHNP-BC and Beth Chadwick, PMHNP-BC. I understand that I am consenting and agreeing only to those services that she is qualified to provide within the scope of their licenses and board certification.

If the patient is under 16 years of age, I have legal custody of this individual named _____, and am authorized to initiate and consent for treatment on behalf of this individual. See signature below as acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF POLICIES REGARDING CONFIDENTIALITY, INFORMED CONSENT STATEMENT AND PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Signature:_____ Date: _____

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