

***Elizabeth Anderson, LMFT***

1440 Kapiolani Blvd, Suite 1200  
Honolulu, HI 96814

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**Patient Registration**

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\_\_\_\_\_  
First Name

\_\_\_\_\_  
Middle Name or Initials

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Age

\_\_\_\_\_  
Gender Identity

**Home Address:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mailing Address:**

Check here if same as  
Home address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Contact Information:**

(Please indicate if contact is for parent or guardian)

*Patient Phone:*

\_\_\_\_\_

**In Case Of Emergency:**

*Contact Name:*

\_\_\_\_\_

*Contact Phone:*

\_\_\_\_\_

*Contact Other:*

\_\_\_\_\_

**What is the main concern that lead you to contact me?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information:**

HMSA       HMSA-QUEST       HMAA       UHA       None

OTHER: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Information:**

HMSA       HMSA-QUEST       HMAA       UHA       None

OTHER: \_\_\_\_\_

Subscriber's Full Name: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

**Primary Care Physician Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Relevant diagnosis under treatment: \_\_\_\_\_

Do you authorize me to communicate with your physician?      Yes       No

## Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another patient, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

### Authorization:

By signing this form, I authorize Elizabeth Anderson, LMFT and office or practice manager to bill appropriate insurance agencies for services provided for the patient named above. I am aware that any payment for services not covered by the patient's health insurance will be my responsibility. My signature below is valid as the original signature for billing purposes.

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Printed Name of Patient

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Date

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Printed Name of Guardian (if patient is a minor)

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Date

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Signature of Adult Patient or Parent/Guardian  
(Please circle "Patient", "Parent", or "Guardian")

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Date