Client Registration

Patient Name:____Today's Date:______________

Address:____________________________City: _______________State:________Zip:___________

SSN:__________________________Birthdate: ______________________Age:__________________

Home Phone #:______________________Cell Phone #: ____________________________________

Referred by:_________________________Family Physician:__________________________________

Employer/School______________________Work Number: ____________________________________

Single_____Married______Divorced______Widowed_________

Responsible Party Information

Name of Person responsible for this account:____

Address:_____________________________City:_______________State:________Zip: __________

Home Phone #:______________________Cell Phone #: ____________________________________

Employer___________________________Work Number#: __________________________________

Email Address:_______________________Cell phone #:____________________________________

Spouse/Significant Other____

Address:___________________________City:_________________State:________Zip: __________

Home Phone #:______________________ Birthdate:______________________________________

Employer___________________________Work Number: ___________________________________

Email Address:_______________________Cell phone #:____________________________________

Subscriber Information

Subscriber's Name:____________________________Phone#:_______________________________

Address:____________________________City: _______________State:________Zip:___________

SSN:_______________________________Relationship to patient:____________________________

Insurance Information:

Primary Insurance:________________________Mental Health Carrier:___________________________

ID#:_______________________Group#:_____________#sessions allowed per year: _______________

How much is your Mental Health deductible?__________Co-pay/co-ins amount: ______________________

Secondary Insurance:______________________Mental Health Carrier:___________________________

ID#:_______________________Group#:______________________ #sessions allowed per year:_____

How much is your Mental Health deductible?__________________ Co-pay/co-ins amount:______________

I authorize the providers rendering service to submit claims to my health insurance company for all covered services rendered in this practice and authorize and direct the health insurance company to issue payment directly to the service corporation. I authorize my provider to furnish complete information to my health insurance company regarding services rendered, and hereby claim the amount of indemnity specified in my contract with my health insurance company.
I understand my provider utilizes an outside medical billing company. I authorize my provider of services to provide pertinent information to their medical billing company for the purpose of submitting claims to my insurance carrier.

____________________________________ _____________________

Signature of patient/Parent **Date**