CLIENT REGISTRATION

PLEASE PRINT INFORMATION CLEARLY – ONE CLIENT PER FORM PLEASE

➤**NAME:** ____________________ ➤**DATE OF BIRTH**: ____________

SOCIAL SECURITY #: ____________________ ➤**GENDER**: ________ ➤**AGE:** ________

MARITAL STATUS : ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

➤**MAILING ADDRESS**: ____

(STREET/APT.) *CITY* *STATE/ZIP*

TELEPHONE: 1) ____________ 2) ____________ 3) ____________

{CIRCLE TYPE} : (*HOME CELL WORK*) (*HOME CELL WORK*) (*HOME CELL WORK*)

EMAIL: ____________________ PARENTS/CAREGIVERS: ____________________

EMERGENCY CONTACT: ____

NAME *PHONE* *RELATIONSHIP*

WHO REFERRED YOU TO THIS OFFICE? ____________________ PCP: ____________________

PCP ADDRESS/PHONE: ____

➤ **PRIMARY INSURANCE CARRIER**: ____________________ ➤**THERAPY IN PAST 12 MONTHS?** ☐ YES ☐ NO

➤**MEMBER ID #:** ____________________ COPAY/DEDUCTIBLE: ____________________

➤**IS THE PATIENT THE INSURANCE POLICY HOLDER?** ☐ YES ☐ NO ✧IF **NO,** THIS INFORMATION IS REQUIRED:

✧POLICY HOLDER'S NAME: ____________________ ✧DATE OF BIRTH: ____________

✧RELATIONSHIP TO PATIENT: ____________________ SOCIAL SECURITY #: ____________

✦EAP: AUTHORIZATION #:____________ ✦START DATE:__________ ✦ # SESSIONS:_____ ✦END DATE:__________

✦ EAP/ SECONDARY INSURANCE CARRIER NAME:____________________ THE FOLLOWING IS REQUIRED FOR BOTH EAP & SECONDARY:

✦MEMBER ID #:____________________ ✦ PATIENT POLICY HOLDER? ☐YES ☐NO ✧ IF NO, THIS INFO IS REQUIRED:

✧POLICY HOLDER'S NAME:____________________ ✧DATE OF BIRTH:____________

✧RELATIONSHIP TO PATIENT:____________________ SOCIAL SECURITY #:____________

Federal regulations allow me and/or my Billing office to use or disclose protected Health Information from your record to provide treatment, obtain payment for the services I provide, and operate my practice. Nevertheless, I ask your consent in order to make your permission explicit. My Notice of Privacy Practices describes these disclosures in greater detail which you have the right to review before signing this consent.

I hereby authorize the provider of service to furnish information requested by my Insurance Carrier and I hereby assign to the provider all payments rendered to myself or my dependents. I understand it is my responsibility to pay for any deductible amount, co-payment, or other allowable balance not paid by the insurance.

➤ **DATE**: ____________ ➤ **SIGNATURE**: ______________________________

CLINICIAN USE ONLY:

➢ THERAPIST: ____________________ TX: ____________ OCR: ☐ YES ☐ NO

➢ INTAKE DATE: ____________ ➢ DX: 1ST ________ 2ND ________ 3RD ________ 4TH ________

SELF PAY RATE: ____________ ________ ________ ________ ________