Client Registration

Last Name ____________________________First Name _____________________________MI________

Address ____

City _________________________________ State __________________________ Zip______________

Home (_____)__________________Work/Cell Phone (______)______________________________

Date of Birth _________________________

Gender ______________Employer ____

Emergency Contact: Name _______________________________ Relationship ________________

Emergency Contact Phone _________________________________

Responsible Party (if different from client listed above)

Last Name ____________________________First Name _____________________________MI________

Address ____

City _________________________________ State __________________________ Zip______________

Home Phone # (_____)__________________Work Phone (______)______________________________

Date of Birth _________________________

Gender ______________Employer ____

Primary Insurance Information

Insurance Company Name ____

Insurance Company Phone ____

ID #_____________________________Group # ____________

Secondary Insurance Information

Insurance Company Name ____

Insurance Company Phone ____

ID #_____________________________Group # ____________

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize payment directly to the provider of services for which benefits are payable. I hereby authorize the release of pertinent medical information to my insurance carriers. I agree to pay at the time of the session any copayment, coinsurance, or, if I have an unmet insurance deductible, fee for service.

____ ______________________________

Signature Date