Client Registration

Last Name _____First Name _____MI_____

Affirmed Name (if different than above) _____

Address _____

City _____ State _____ Zip_____

Phone (_____)_____

Date of Birth _____

Gender _____ Pronouns _____

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