Client Demographics and Registration

Name: _____ Birthdate: ___/ ____/ ____ Male___ Female ___

Home Address _____ City _____ State_____ Zip _____

Mailing Address _____ City _____ State_____ Zip _____

Marital Status M S W D Social Security # _____-_____-_____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Employer _____ Address_____ City/State _____

Person to notify in case of emergency: _____ Relationship: _____

Contact information: _____

Person Responsible for Bill _____ Relationship_____

Address_____ City _____ State_____ Zip _____

Insured's Name _____ Social Security # ____-_____-_____

Insured's Date of Birth ___/ ____/ ____ Employer _____

Policy # _____ Group # _____

Secondary Insurance Company _____ Phone ( )_____

Address_____ City _____ State_____ Zip _____

Insured's Name _____ Social Security # ____-_____-_____

Insured's Date of Birth ___/ ____/ ____ Employer _____

Policy # _____ Group # _____

I hereby assign all insurance money paid to me to compensate expenses for therapy services. I understand that I am responsible for all charges incurred by me regardless of insurance coverage. I understand that any money paid by my insurance in excess of my therapy fees will be refunded to me when my account is paid in full. I authorize the disclosure of medical records to my insurance company if needed. It is understood and agreed that all accounts are due and payable at the time services are rendered. It is further understood that if at least 24 hours notice is not given at the cancellation of any appointment, a charge may be made for the full cost for the time reserved. Insurance does not cover canceled or missed appointment.

Signed_____ Relationship_____ Date_____