CLIENT REGISTRATION INFORMATION

_____ New Client ____ Change of Client Info-Effective_____ **Provider:** _____

PERSONAL INFORMATION

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
HOME/CELL PHONE: _____
WORK PHONE: _____
EMAIL ADDRESS:_____
DATE OF BIRTH: _____
GENDER: _____
MARITAL STATUS: _____
EMERGENCY CONTACT: _____RELATIONSHIP_____
PHONE NUMBER: _____

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
INSURANCE CO CITY/STATE/ZIP: _____
INSURANCE CO PHONE #: _____
IDENTIFICATION #: _____
SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____
RELATIONSHIP TO CLIENT: _____
SUBSCRIBER EMPLOYER: _____
GROUP #: _____
SECONDARY INSURANCE CO: _____
SECONDARY INSURANCE ID#: _____
PRE-CERTIFICATION #:_____

Authorization to Pay Insurance Benefits: I hereby direct my insurance carrier to make payments directly to the Provider for health insurance benefits otherwise payable to me, but not to exceed the Provider's regular charges. I understand that I am financially responsible for charges not covered by this authorization (including insurance co-payments and deductibles that are• due at the time of service). This assignment of benefits shall be valid for the duration of my treatment.

Signature of Client/Guardian_____ Date: _____

Authorization For Release of Information: I hereby authorize the Provider and his/her office billing staff or agency to release billing and medical information to my insurance company necessary to process claims for services rendered to me by the Provider. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information which by law may only be released by specific consent.

Signature of Client/Guardian_____ Date: _____

Dx: _____