

PROVIDER:**REGISTRATION INFORMATION**

Referring Doctor:

CLIENT INFORMATION

CLIENT FULL LEGAL NAME:		DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> TRANS
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> PARTNERED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER	EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SELF-EMPLOYED <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY	STUDENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME	
ADDRESS		CITY/STATE/ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL ADDRESS		OK TO DISCUSS SCHEDULING VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO	

EMERGENCY CONTACT

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE
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RESPONSIBLE PARTY (IF MINOR OR GUARDIAN)

FULL LEGAL NAME	RELATION TO CLIENT <input type="checkbox"/> BIOLOGICAL PARENT <input type="checkbox"/> STEP-PARENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> MINOR
ADDRESS	CITY/STATE/ZIP
PHONE	LEAVE MSG? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMAIL ADDRESS	OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.**PRIMARY INSURANCE NAME #1**

POLICY #:	GROUP #:	RELATIONSHIP TO CLIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
POLICY HOLDER:	SS #:	
INSURED DATE OF BIRTH:	EMPLOYER:	

SECONDARY INSURANCE NAME #2

POLICY #:	GROUP #:	RELATIONSHIP TO CLIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT
POLICY HOLDER :	SS #:	
INSURED DATE OF BIRTH :	EMPLOYER:	

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE TIME OF YOUR APPOINTMENT

* Policies with a DEDUCTIBLE or Out of Network Insurance				DO YOU HAVE A HSA CREDIT CARD? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>NOTE: A deductible REQUIRES a non-HSA credit card on file as a back-up to any HSA</i>				
<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> DISCOVER	EXP DATE	CVV CODE	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> DISCOVER	
CARD NUMBER				HSA CARD NUMBER				
CARD HOLDER NAME				CARD HOLDER NAME				
<i>I hereby give consent to charge my credit card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.</i>				<i>I hereby give consent to charge my HSA card below for any outstanding balance such as deductibles, co-payments, fees or other amounts my carrier determines as payable by me.</i>				
CARD HOLDER SIGNATURE				DATE	CARD HOLDER SIGNATURE			
					DATE			

CLIENT FULL LEGAL NAME:		DATE OF BIRTH:	
PRIVATE PAY Payment due IN FULL at the time of Service.			
SERVICE DESCRIPTION (EXAMPLE: INTAKE)	RATE/UNIT (EXAMPLE: \$200/45-50 MIN) \$ /	SERVICE DESCRIPTION	RATE/UNIT \$ /
IMPORTANT SIGNATURES			
CLIENT FULL LEGAL NAME		DATE OF BIRTH	
<i>if client is a minor, please print full legal name of parent/guardian(s) signing on behalf of the client:</i>			
PRINT FULL LEGAL NAME		RELATIONSHIP TO CLIENT	
PRINT FULL LEGAL NAME		RELATIONSHIP TO CLIENT	
INSURANCE BILLING			
I authorize _____ (hereinafter called Medical Practice) to release any medical information to our billing company for paper & electronic billing of your insurance company. I authorize my insurance company to assign benefits to Medical Practice, I understand that I am responsible for payment for services rendered by Medical Practice regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify the Medical Practice immediately whenever I have changes in my health plan coverage.			
ACCOUNT RESPONSIBILITY			
I am responsible for payment to Medical Practice for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, the Medical Practice reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names the Medical Practice as a creditor in any bankruptcy filing.			
INFORMED CONSENT & NOTICE OF PRIVACY PRACTICES			
I am consenting to treatment and have received and understand the contents of the Policies, including the Notice of Privacy Practices (HIPAA).			
<i>My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all of the terms and conditions of the Policies. If I have questions, the information has been explained and/or summarized for me.</i>			
SIGNATURE(S) (CLIENT OR LEGAL GUARDIAN)		DATE	
SIGNATURE(S) (LEGAL GUARDIAN)		DATE	

IMPORTANT NOTICE TO ALL PATIENTS

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL INSURANCE POLICY. MANY INSURANCE POLICIES HAVE EXCLUSIONS, AND MOST HAVE DEDUCTIBLES, AND CO-PAYMENTS / CO-INSURANCE. SOME INSURANCE POLICIES MAY NOT COVER OUR SERVICES.

IT IS IMPORTANT FOR YOU TO CHECK WITH YOUR INSURANCE CARRIER TO DETERMINE IF THE PROVIDER YOU ARE SEEING IS LISTED AS AN "IN-NETWORK" PROVIDER. IF THEY ARE NOT LISTED AS AN "IN-NETWORK" PROVIDER YOU MAY HAVE A HIGHER DEDUCTIBLE AND OR CO-PAY.

REGARDLESS OF INSURANCE COVERAGE, YOU ARE RESPONSIBLE FOR ALL BILLS NOT COVERED BY YOUR INSURANCE POLICY.

Signature of Patient/Guardian

Date