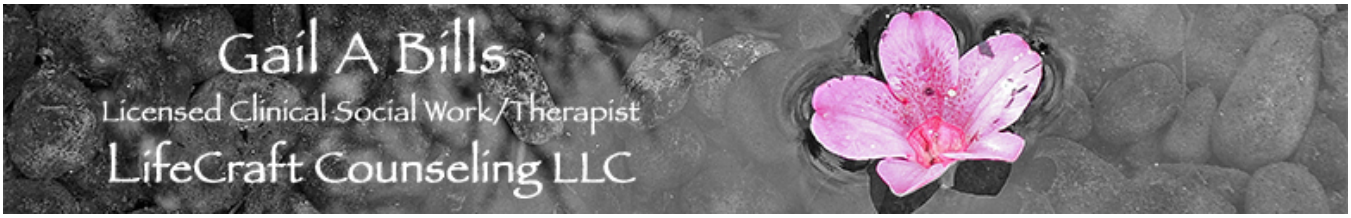

REGISTRATION FORM

Today's Date:	

CLIENT INFORMATION

Client's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Other ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security no.:	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Home phone : ( )	Cell or other number (optional) ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employment/work phone no.: ( )

May I contact you and/or leave a message at any /all of the above numbers? ☐ Yes ☐ No	If it is OK for me to contact you by email, please provide e-mail address :

INSURANCE INFORMATION

(Please provide your insurance card to be photocopied.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance? ☐ Yes ☐ No	Insurance company:

Policy holder's name:	Policy holder's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Client's relationship to policy holder:	☐ Self	☐ Spouse	☐ Child	☐ Other

Secondary insurance company (if applicable):	Secondary policy holder's name and birthdate	Group no.:	Policy no.:

Client's relationship to secondary policy holder :	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative to be contacted in emergency:	Relationship to patient:	Home phone no.: ( )	Work or cell phone no.: ( )

The above information is true to the best of my knowledge. I, the undersigned, authorize and assign to Gail A. Bills, LCSW, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the balance and for all charges whether or not paid by insurance. I hereby authorize Gail A. Bills, LCSW, to release any information required to process my claims. I permit a copy of this authorization to be used in place of the original on all insurance claims. I acknowledge having received a copy of the Notice of Privacy Practices describing how medical information about me may be used and disclosed and my rights regarding this information.

Patient Signature (or Parent/Guardian for minor) *Date*

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