CLINICIAN INFO HERE

CLIENT REGISTRATION

Date: _____/_____/_____ Appt Date/Time: _____ Referred by: _____

Client Name: _____ **Date of Birth**: _____/_____/_____

❑ *May leave a message at this number*

Street Address: _____ **Home No: ( ) _____**

❑ *May leave a message at this number*

City/State/Zip: _____ Work/Cell: ( ) _____

Guarantor of Client (if other than client): _____ SS #: _____

Relationship: Parent Spouse Other: _____ Telephone: ( ) _____

Circle One

In Case of Emergency Contact:

Name/Relationship/Telephone Number(s)

MEDICAL CONSENT

I consent CLINICIAN NAME to provide evaluation and treatment to my child or me. In the event of an emergency, I authorize Ann Sullivan, LICSW to transfer my child or me to a hospital or another medical facility. I understand that I may terminate treatment at anytime.

_____ _____/_____/_____

Signature or authorized person's signature *date*

CLIENT'S SIGNATURE WAIVER

I authorize payment of medical benefits to be made either to me or to the party that accepts assignment. I understand that if payment should be made directly to me, it is my responsibility to make payment to the provider of services.

_____ _____/_____/_____

Insured or authorized person's signature *date*

RELEASE OF INFORMATION

I authorize the release of medical information necessary to process insurance claims for related services.

_____ _____/_____/_____

Insured or authorized person's signature *date*

NOTICE OF INSURANCE RESPONSIBILITY

I am aware that it is my responsibility to understand my health insurance benefits. My clinician and his or her staff can help familiarize me with these benefits and give the best estimation of insurance status and remaining benefits, however, I know that it is not their responsibility if I am not informed when my benefits are about to be exhausted or have been exhausted. I am aware that I am responsible for all deductibles, co-payments, co-insurance, client balance and any balance not paid by my insurance company.

_____ _____/_____/_____

Insured or authorized person's signature *date*

<u>Primary Insurance</u>
Name:
ID No:
Subscriber Name:
Subscriber Date of Birth:
Telephone No on Card:

<u>Secondary Insurance</u>
Name:
ID No:
Subscriber Name:
Subscriber Date of Birth:
Telephone No on Card:

OFFICE USE ONLY

Benefits:

❑ **Eligible for Mass Parity**

Copay/Pat Resp: _____

Authorization: _____ No of Sessions: _____ Effective Dates: ___/___/___ to ___/___/___