Adult Client Registration Form

Today’s Date / / Date of Birth: / /

Full Name:

Home Address \_\_\_\_\_\_\_City: \_\_ State: \_\_\_\_ Zip: \_\_\_

Mailing Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have authorization to send mail to the address listed above?  yes  no

Phone: (H) \_\_(O)\_\_\_ (C)\_ \_\_\_\_\_

May we leave a message?  yes  no May we text?  yes  no

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred method of contact:  Phone  Text  Email

Family Physician: Phone Number:

Date of last physical:

Medical Conditions:

Current Medications:

Allergies:

Referred by: \_\_\_\_\_\_\_\_

Emergency Contact: Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INSURED/RESPONSIBLE PARTY INFORMATION

All items in this section must be completed to bill your insurance.

Policy Holder’s Full Name: DOB:

Policy Holder’s SS #: Relationship to Client:

Home Address: Phone #:

Employer and Address: Phone #:

* Single  Married  Employed  Unemployed  Retired  Disabled

Please provide the phone number on the back of insurance card that says mental health, behavioral health, or benefits below.

Client’s Primary Ins. Co. ID#:

Group#: Mental Health Phone #:

Copay: $ (this amount is due at each session, to make payment arrangements please contact your therapist)

Client’s Secondary Ins. Co. ID#:

Group#: Mental Health Phone #:

AUTHORIZATION

I authorize treatment deemed necessary by Compass Counseling Center Practitioners. I authorize Compass Counseling Center to release to my health plan any and all information which he/she deems necessary regarding my care and treatment to ensure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Compass Counseling Center for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Compass Counseling Center for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicaid, or to other contractual provisions that may limit a patient’s responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

Client Signature (Office Policies & Authorization to Treat) Date