PROVIDER:

REGISTRATION INFORMATION

Referring Doctor:

CLIENT INFORMATION

CLIENT FULL LEGAL NAME: | DATE OF BIRTH | GENDER ☐MALE ☐FEMALE ☐TRANS

MARITAL STATUS ☐SINGLE ☐MARRIED ☐PARTNERED ☐SEPARATED ☐DIVORCED ☐WIDOWED ☐OTHER

EMPLOYMENT STATUS ☐FULL TIME ☐PART TIME ☐SELF-EMPLOYED ☐RETIRED ☐ACTIVE MILITARY

STUDENT STATUS ☐FULL TIME ☐PART TIME

ADDRESS | CITY/STATE/ZIP

HOME PHONE | CELL PHONE | WORK PHONE

EMAIL ADDRESS

OK TO DISCUSS SCHEDULING VIA EMAIL? ☐YES ☐NO

OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐YES ☐NO

EMERGENCY CONTACT

EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE

RESPONSIBLE PARTY (IF MINOR OR GUARDIAN)

FULL LEGAL NAME

RELATION TO CLIENT ☐BIOLOGICAL PARENT ☐STEP-PARENT ☐LEGAL GUARDIAN ☐MINOR

ADDRESS | CITY/STATE/ZIP

PHONE | LEAVE MSG? ☐YES ☐NO | EMAIL ADDRESS | OK TO SEND RECEIPTS OR STATEMENTS VIA EMAIL? ☐YES ☐NO

INSURANCE INFORMATION Copy of both sides of the insurance card(s) needed at intake.

PRIMARY INSURANCE NAME #1

POLICY #: | GROUP #: | RELATIONSHIP TO CLIENT ☐SELF ☐SPOUSE ☐DEPENDENT

POLICY HOLDER: | SS #:

INSURED DATE OF BIRTH: | EMPLOYER:

SECONDARY INSURANCE NAME #2

POLICY #: | GROUP #: | RELATIONSHIP TO CLIENT ☐SELF ☐SPOUSE ☐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

☐ VISA ☐ ☐ DISCOVER | EXP DATE | CVV CODE

CARD NUMBER

CARD HOLDER NAME

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.

CARD HOLDER SIGNATURE | DATE

DO YOU HAVE A HSA CREDIT CARD? ☐YES ☐NO *NOTE: A deductible REQUIRES a non-HSA credit card on file as a back-up to any HSA*

☐ VISA ☐ ☐ DISCOVER | EXP DATE | CVV CODE

HSA CARD NUMBER

CARD HOLDER NAME

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.

CARD HOLDER SIGNATURE | 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 YOUT O 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.

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Signature of Patient/Guardian Date