Client Registration

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(PLEASE PRINT. FILL OUT COMPLETELY.) Today's Date: ___/___/___

Patient's Full Name: _____

Home Address: _____ City: _____ State: _____ Zip:_____

Home Phone: ( )_____Cell: ( )_____ Sex:_____ Age:_____ Date of Birth: ___/___/___

Patient Employer: _____Hire Date:_____ Employer's Phone Number: ( ) _____

If Student, Name of School:_____ H.S. _____ College:_____

Family Physician: _____Referred By: _____

Person to Contact in Emergency: _____ Phone: ( ) _____

INSURED/RESPONSIBLE PARTY INFORMATION

Please complete this section regardless of insurance coverage.

Full Name of Insured: _____

Relationship to Patient:_____ Occupation:_____Date of Birth: _____

Home Address: _____City: _____State:_____Zip:_____

Phone: ( ) _____

Employer: _____Employer's Address:_____Hire Date:_____

Employer's Phone: ( )_____ Driver's Lic.#:_____

Full Name of Spouse: _____Date of Birth: _____

Spouse's Employer: _____Phone: ( ) _____

Insured's Primary Insurance Co.: _____ ID#: _____Group#:_____

Secondary Insurance Co: ____No _____Yes Company: _____ Policy#:_____

Job Related Injury-Workers Comp. Co.:No ____ Yes____; Company:_____

OFFICE, BILLING, AND INSURANCE POLICIES

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s)and managed care company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.
6. I understand that Bruce A. Fountain, MS, LMFT is a sole practitioner and not part of any group practice.

Name: _____

Signature: _____ Date: _____