Counseling & Consulting, LLC

Psychological Consulting Center

Registration Form

Thank you for choosing us to assist you with your therapeutic needs. Please answer the following questions so that we may be of complete and accurate service to you and read and sign the accompanying forms.

Name:_____________________________DOB:___________ Education___________________
Address: ______________________________City:__________________ Zip:_______________
Home Phone:_________________________ Work Phone: __________________Ext:_______
Cell Phone:__________________________ Preferred Language:____________________________
Employer:___________________________ Occupation:_______________________________
Address: ____________________________ City:____________________ Zip:____________
E-Mail: _________________________________
Social Security Number: ____________________________ **Religion:** ____________________

Relationship Status:

Single (never married)___ Cohabitating (living together)___
Remarried (after Spouse death) ___ Remarried (after divorce)___Significant other __
Separated ___ Divorced ___ Widowed ___ First Marriage ___

Spouse / Partner: ____________________________________ DOB:________________
Address if different: __________________________________ Phone:________________
Employer:___________________________________ Work Phone:________________________
Occupation: ________________________________ E-mail:____________________________
Children and household members (names and ages):
____
____

Referred by: _______________________________ May I thank this person for the referral? Y N
Insurance: Information: (Please allow us to make a photocopy of your ID and insurance card)
Insured Name:_____________________________________ SSN:__________________________
Insurance Company: ________________________________ Phone:_________________________
Address: ____ City:________________ Zip______
Personal ID #:_____________________________________ Group #:_______________________
Effective Date: ____________________________________ Contract #:_____________________
Emergency Contact__________________________________ Phone: ________________________
Religion:________________________________Language preference:_______________________

I hereby consent and authorize this provider to make any and all insurance claims on my / our behalf. I understand that all questions concerning insurance reimbursements and financial responsibility are to be discussed with my therapist. I **do / do not** consent and authorize this provider to disclose information to my primary care provider for the purpose of continuity of care.

Signature:___________________________________ Date:__________________________