



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) ___ Cohabiting (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: _____