The Center for Counseling & Training

Client Registration Form

Date: ____________________ D.O.B. ________________________

Full Name: _________________________________ SS#_______________________ Gender: M☐ F☐

Address: ___________________________________ City: __________________ State: _______ Zip: _____________

Phone Number: ___________________ Is this a cell phone?________ Alt Number: ______________________

Email: ___________________________________ Is it ok to contact you by email?__________

Name of Parent/Guardian (if applicable):__________________________________ Relationship: ____________________

Address: ___________________________________ City: __________________ State: _______ Zip: ______________

Phone Number: _____________________________ Work Number: ______________________________

Emergency Contact Information:

Name: ____ Relationship: ____

Address: ___________________________________ City: __________________ State: _______ Zip: _______________

Phone Number: ___________________ Alternate Number: ___________________ Work: __________________________

Primary Insurance:

Name of Insured: ____________________________ D.O.B. ______________ SS#: ________________________

Insured's Employer:_____________________________________

Relationship to Insured:☐Self ☐Parent☐Spouse ☐Guardian ☐Other: ______________________________

Address: _______________________ City: _____________ State: _______ Zip: ___________ Phone: _______________

Insurance Company: ________________________ ID#: ___________________ Group #: __________________________

Address: __________________________ City: _______________ State: ____ Zip: _________ Phone: ________________

Secondary Insurance (if applicable):

Name of Insured: ____________________________ D.O.B. ______________ Phone Number: ____________________

Address: ___________________________________ City: __________________ State: _______ Zip: _______________

Insurance Company: ________________________ ID#: ___________________ Group #: __________________________

Address: __________________________ City: _______________ State: ____ Zip: _________ Phone: ________________

☐ I do not have insurance or am not using insurance for this/these service(s). I have agreed to pay $_______ per session.

I authorize release of any information concerning my or my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to The Center for Counseling & Training, LLC, et al.

Signature of Responsible Party ____ Date ___________________

Rev. 1/28/16