



The Center for
**COUNSELING
& TRAINING**

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 _____