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PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Address: _____City/State _____ Zip: _____
Home/Evening Phone: _____ Cell Phone: _____ Email: _____
Which number would you like us to use for appointment reminders? _____
May we leave a message on your voice mail? ___ Yes ___No If not, how should we contact you? _____
Social Security #: _____ Sex: M F Marital Status: Single Married Separated Divorced Widowed
Employer: _____ Position: _____ Work Hours: _____

Referral: Who gave you my name to call? _____ Phone: _____
May I have your permission to thank this person for the referral (If it was a provider)? ___ Yes ___ No
How did this person explain I may be of help to you? _____
Primary Care Provider: _____ May I have permission to speak to your doctor? ___ Yes ___ No

PARTNER INFORMATION (Who would you like us to contact in an emergency?)

Name: _____ Age: _____ Date of Birth: _____ Sex: M F
Address: _____City/State _____ Zip: _____
Home/Evening Phone: _____ Cell Phone: _____ Email: _____
Employer: _____ Position: _____ Work Hours: _____

CUSTODIAL ADULT INFORMATION (If the patient is a child please complete the following regarding the custodial parent(s))

Name: _____ Age: _____ Date of Birth: _____ Sex: M F
Employer: _____ Position: _____ Work Hours: _____
Social Security #: _____ Sex: M F Marital Status: Single Married Separated Divorced Widowed
Home/Evening Phone: _____ Cell Phone: _____ Email: _____
Which number would you like us to use for appointment reminders? _____
May we leave a message on your voice mail? ___ Yes ___ No If not, how should we contact you? _____

INSURANCE

Primary Insurance Co: _____ Insured's Name: _____
Address (Where to mail claim): _____ Phone: ( ) _____
ID No. _____ Group No. _____ Insured's SS#: _____

Secondary Insurance Co: _____ Insured's Name: _____
Address (Where to mail claim): _____ Phone: ( ) _____
ID No. _____ Group No. _____ Insured's SS#: _____

CONSENT TO SERVICES: By signing this registration form, I request, and agree to pay for, mental and/or addiction health services to be provided for myself and/or my family/child. I acknowledge that I have received, have read (or have had read to me), and understand the "Informed Consent." I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. If I am requesting services on behalf of a minor, I certify that I am the legal guardian. I also agree to pay any and all collection costs incurred, should it become necessary. I understand I will be charged $75.00 for scheduled appointments missed without a 24 hour **or one full business day** cancellation notice. I also understand that Dr. Rogers, and/or her office staff, need to use this information for scheduling, test administration or scoring, and filing insurance claims. If I am requesting insurance coverage, I also acknowledge this information will be used to arrange payment for treatment. My signature below acknowledges that I have read or heard the notice of privacy practices, which explains my rights and how my PHI will be used.

My signature below shows that I understand/agree with all of these statements.

Signature: _____ Date: _____