C.A. COUNSELING & CONSULTANTS, LLC.

REGISTRATION FORM

CLIENT INFORMATION

Date of Registration ____________________ Referred By ___________________________________

Client Name ____ Sex __________ Birthdate ________________

Address____

City/State/ Zip ____

Home Phone ___________________________________ Cell Phone ____________________________________

Phone number you want used for courtesy appointment reminder call ______________________

Email Address ____

Employer ____ Work Phone ______________

Employer Address ____

City/State/Zip ____

Marital Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed

Student Status: ______ Full Time ______ Part Time ______ Not a Student

Emergency Contact ____________________________________ Relationship __________________________

Emergency Contact Phone ____________________________

BILLING INFORMATION *(Please complete if person responsible is not the client)*

Name of Responsible Party ____

Relationship to Client ____

Address ____

Social Security # ____________________ Birthdate _________________________

Home Phone ________________________ Cell Phone _______________________

Employer ____ Work Phone ________________________

Employer Address ____

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REGISTRATION FORM

INSURANCE INFORMATION

______ ***Please check if you do not have Medical/ Health Insurance Coverage.***

If you would like us to bill your insurance, please complete the following section. If insured, please provide your Insurance Card(s) so we can make a copy of the front and back.

PRIMARY INSURANCE

Highlighted fields required (if you do not have your insurance card we will need the entire section completed)

Primary Insurance Company: ____

Subscriber SS#: ______________ Subscriber or ID #: ______________ Group/File #: ________

Full Name of Policy Holder: ______________________________ Date of Birth: ________

Address ____________________________ Phone (____) ______________________

Employer: ____

Client Relationship to Insured: ____ Self ____ Spouse ____ Child ____ Other

Effective Date of Coverage ____________________

Is pre-authorization required? ___ Yes ___ No Has pre-authorization been obtained? ___Yes ___No

Primary Insurance Company: ____

Subscriber SS#: ______________ Subscriber or ID #: ______________ Group/File #: ________

Full Name of Policy Holder: ______________________________ Date of Birth: ________

Address ____________________________ Phone (____) ______________________

Employer: ____

Client Relationship to Insured: ____ Self ____ Spouse ____ Child ____ Other

Effective Date of Coverage ____________________

Is pre-authorization required? ___ Yes ___ No Has pre-authorization been obtained? ___Yes ___No

□□

- I hearby authorize release of information necessary to file a claim with my insurance and assign benefits otherwise payable to me to be paid to the provider on the claim form.
- I authorize C.A. Counseling to provide medical records to insurance companies.
- I agree that any fee not covered by insurance will be paid at the time of service including co-pays, co-insurance, and deductibles.
- I understand that I am responsible for getting pre-authorization from my insurance carrier for my first visit.
- I have read and agree to the Client Financial Policy. I understand 24 hour notice is required for any cancellations or I will be billed $100.00. This is not a billable charge to your insurance company.
- It is my responsibility to notify the office of any changes in my insurance plan otherwise I will be responsible for charges.
- A copy of my signature is as valid as the original.

I have read and understand my responsibilities as a client of C.A. Counseling & Consultants, LLC.

Client Signature ________________________________ **Date** ____________________

Parent/Guardian Signature (if applicable) ________________ **Date** ____________________

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<u>REGISTRATION FORM</u>

FINANCIAL AGREEMENT AND COMMERCIAL ASSIGNMENT OF BENEFITS

You are responsible for your entire bill. However, we will submit claims to your insurance company as a courtesy to you. We suggest that prior to your first appointment you understand the mental health benefits provided by your insurance plan. You should understand the amounts of your co-payments (the portion of the charge your insurance company expects you to pay) and the deductibles (the amount your insurance company requires you to pay before benefits begin). You should be aware of the plan restrictions and benefit limits. Many insurance companies require pre-authorization for mental health services. Some insurance plans place restrictions on the type of services covered and/or on the frequency or number of appointments covered. Please let our office administrator or your therapist know about these requirements and restrictions prior to your first appointment. I authorize the release of information by C.A. Counseling & Consultants, LLC; to the extent that disclosure of my medical records is necessary for billing, collection or payment of claims. I release C.A. Counseling & Consultants, LLC from all legal responsibility or liability that may arise from this act. I assign benefits to C.A. Counseling & Consultants, LLC, for charges incurred by eligible persons covered under my current or subsequent plan. Reimbursement is subject to eligibility and plan limitations. I agree by my signature below that photocopies of this authorization may be used in insurance claims and the "Signature on File" may be used in lieu of my actual signature thereon. I have been informed of the charges for treatment and agree to be directly responsible for all charges which insurance will not pay. I fully understand and will comply with the above expectations.

By signing below, I am acknowledging I have received, read, and understand the above policies and hereby agree to them:

Client's Signature: ______________________________ **Date**: ______________

Responsible Party Signature: ______________________________ **Date:** ______________