



ADULT CLIENT REGISTRATION FORM

(Please Print)					
Today's Date	Appt. With		Whom may we thank for referring you?		
CLIENT INFORMATION					
Last Name, First Name, Middle Initial				Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary
Street Address			City	State	Zip Code
Preferred Phone #	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	Confidential Msg/Txt <input type="checkbox"/> Yes <input type="checkbox"/> No	Alternate Phone #	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	Confidential Msg/Txt <input type="checkbox"/> Yes <input type="checkbox"/> No
Email Address			Please send me Appointment Reminders by: Email <input type="checkbox"/> Yes <input type="checkbox"/> No Text Message <input type="checkbox"/> Yes <input type="checkbox"/> No I prefer not to receive appointment reminders <input type="checkbox"/>		
Please sign me up for the email list for practice updates: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Employer's Name, Address, and Work Phone (Confidential VM <input type="checkbox"/> Yes <input type="checkbox"/> No)					
If someone else answers your phone, with whom may we leave a verbal message about your appointment scheduling? With whom may we discuss billing?					
Anything else you would like us to know about communicating with you or your family					
Psychiatrist			Phone:	Notify of your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Care Physician			Phone:	Notify of your visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IN CASE OF EMERGENCY					
Last Name, First Name, Middle Initial				Relationship to you	
Preferred Phone #	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	Confidential Msg/Txt <input type="checkbox"/> Yes <input type="checkbox"/> No	Alternate Phone #	<input type="checkbox"/> Cell <input type="checkbox"/> Landline	Confidential Msg/Txt <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer's Name and Work Phone (Confidential VM <input type="checkbox"/> Yes <input type="checkbox"/> No)					

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PRIMARY INSURANCE INFORMATION		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)		
Insured's Last Name, First Name, Middle Initial		Birth Date
Insurance Company		Phone Number
Insurance Billing Address		
Policy No.	Group No.	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<p>The above information is true to the best of my knowledge. I authorize CORE Connection Counseling to use and disclose my private health information for treatment, payment, and health care operations. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. Furthermore, I have reviewed the Notice of Privacy Practices and Client Information Brochure provided. I fully understand and accept the terms of this practice. I have had the opportunity to ask questions which clarify the conditions under which I consent to treatment and give my permission to CORE Connection Counseling to provide me with evaluation, consultation, and/or psychotherapy.</p>		
Signature _____		Date _____

Authorization to Secure Payment

I, _____ authorize CORE Connection Counseling to process payment on my Visa, MasterCard, American Express or Discover for any balance due that has not been paid **30 days after my bill is received. These charges will appear from Colleen Hanson, LCSW, P.C.** I understand that if my card is declined, CORE Connection Counseling may put my payment through on another day when funds become available. I further understand that if I miss a scheduled appointment and fail to provide 24 hours advance notice, I will be billed a fee of \$85 and my credit card will be charged per the statement above. I understand that I have given CORE Connection Counseling my Credit Card information. I have read and understand this authorization to secure payment.

We are able to scan your credit card and store securely if you would prefer this to entering below. Missed appointment fees will not be processed to a spending account card so if this is your primary card on file, we do require an additional debit or credit card for this purpose.

My credit card information is as follows:

Name on Credit Card

Signature of Card Holder Date

Credit Card Account Number

Expiration Date 3-4 Dig. Sec. Code Zip Code of CC Billing Address

Is this a debit card? Yes No

Is this a spending account card? Yes No