



REGISTRATION FORM

Client Name: _____ Date of Birth: _____ Sex: M F Date: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____ Marital Status: S M D W O

Email: _____ Employer/School: _____

Referred by: _____

If client is a minor, name of both father and mother: _____

Emergency Contact Name/Relation _____ Cell No.: _____

Primary Care Physician/Psychiatrist: _____ Phone: _____

Person Responsible for the account: _____ Relationship to client: _____

Date of Birth: _____ Email: _____ Phone No.: _____

Insurance Information:

Name of Primary Insurance: _____ Phone No. : _____

Insurance ID #: _____ Group No.: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's Address: _____
(If different than client) (Street) (City) (State) (Zip)

Employer: _____ Preferred Phone No.: _____

Relationship with client: Self Spouse Child Other: _____

Have you verified benefits prior to your first appointment? Yes No

Do you have secondary insurance? _____

Signature for consent to be treated by CORE Connection Counseling providers:

Signature of client: _____

Signature of parent: _____ (if client is a minor)

Client name _____

How may we contact you for appointments, reminders and accounts?

Home Phone: _____ May we leave a voice message? Yes No

Cell Phone: _____ May we leave a voice message? Yes No Text? Yes No

Please circle which phone number is preferred: Home/Cell? Email: _____

Do you want appointment reminders? If yes, please check how reminder should be sent to the preferred phone and/or email above.

Email only _____ Text and email _____ No reminders _____

(*Please note: Email correspondence is not considered to be a confidential medium of communication.)

Credit/Debit card on File:

To receive services we request an active credit card number be held on file. We will use the card on file for insurance copayments, and late cancel/missed appointment fees, or for balances over 30 days.

For self-pay clients we will use the card on file for appointment fees in addition to other applicable charges above unless alternate payment is made at time of service.

We are able to scan your card into our billing system which is preferred if you have the card available at the time of intake.

if not please enter your card information and sign below giving consent to use the card on file

Credit Card Number: _____ Circle one: Visa MC Discover

Expiration Date: _____ Security Code: _____ Name on card: _____

Billing address if different than home address: _____

I authorize CORE Connection Counseling/Colleen Hanson, LCSW, P.C. to bill the card on file for fees on the account for client listed above.

Signature of cardholder

Date