Sacred Space Counseling
Hope · Healing · Freedom

REGISTRATION

Date: _____

Name: _____
Last First Middle

If client is a minor, client lives with _____
*Relationship*_____

Birth date:_____ Age:_____ Gender: M or F Social Security #:_____

Address:_____
Street City State Zip

Phone(Home):(___)_____(Cell): (___)_____

(Work) (___)_____

Ok to leave message? (circle) YES NO I**ndicate home, cell or work**

Email _____

Marital Status:_____ Spouse/partner name:_____

Occupation:_____ Employer:_____

RESPONSIBLE PARTY: If other than the Client, Please Complete

Name_____ Relationship to client _____

Address (if different than above) _____
_____

Phone (home) (___)_____ (Work) (___)_____ Social Security#_____

Birth date _____ Employer Name and Address _____
_____

EMERGENCY CONTACT: Nearest Friend or relative not living with you

Name_____Relationship to Client _____

Address_____

Phone (___)_____

INSURANCE INFORMATION

Primary Insurance company

_____ Phone (___)_____
Name of Company

Contract #_____ Group # _____

Subscriber Name _____Date of Birth _____

Address _____ Phone _____

Social Security #_____

Secondary Insurance company

_____ Phone (___)_____
Name of Company

Contract #_____ Group # _____

Subscriber Name _____Date of Birth _____

Address _____ Phone _____

Social Security #_____

Financial Responsibility Statement/ Release of Information Authorization

"I authorize Sacred Space Counseling to contact my employer and my insurance company in order to verify insurance benefits. I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Provider for services received. I also authorize the release of information to listed physicians and/or individuals."

X_____ _____
Signature of Client or Legal Guardian Date

"I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my provider and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees."

X_____ _____
Signature of Client or Legal Guardian Date