Registration Form

Clinician's Name : Felicia Glick -Oberwise, MSW,LCSW

Client Demographic Information

Client Name:____________________________________, __________________________________,_______________
(Last) **(First)** **(Middle Initial)**

Date of Birth: _____/_____/_____ AGE ______ Gender (Circle): M /F Marital Status (Circle): S M W D

How May your Clinician Communicate with You ?

Please Check the Phone Numbers where it is OK to Contact You and Leave a Message.

❑ Home Ph _____/_____/________ ❑ Cell Ph _____/_____/_________ ❑ Other Ph _____/_____/________ext_______

E-Mail Address____ **Ok to send correspondence or statements? Y/N**

Who will be the Financially Responsible Party?

❑ Client ❑ Insured Person (other than client) ❑ Other______________________

Please list Both Addresses and ☐ **Check which you would like mail sent to.**

❑**Client Address**

Street Address

____City____________________ST_______Zip______________

❑**Subscriber Address** ❑**Same as above**

Street Address

____City____________________ST_______Zip______________

Is The Client a Minor? Please list all legal guardians and their phone numbers.

Mother's Name____ Phone # _____/_____/________

Father's Name ____ Phone # _____/_____/________

Other____ Phone # _____/_____/________

Reason for Seeking Treatment ____

Who Referred You? ____

Emergency Contact Person: ____Relationship________________________

Ph ________/________/____________

Registration Form (page 2)

Client Name: ____

Clinician Name: ____

Insurance Information

Primary Insurance ❑ **No Insurance / Self-Pay**

Policy Holder / Subscriber Name ____

Insured Relationship to the Pt : (Circle) Self, Spouse, Parent, Step Parent, Other ____________

Subscriber's Date of Birth _____/_____/_____ SS# _____/______/________ Place of Employment ____________

Name of Insurance Co: ______________________________ (Circle) PPO, HMO, POS

Customer Svc Ph # _______/_______/________ MH/ SA Provider Ph # ______/______/_______

Subscriber Identification # ____________________ Group # ____________________

Insurance Claims/

MailingAddress____

________________________City____________ST_______Zip_________

Do you have Secondary Insurance? ❑**Yes** ❑ **No Secondary Insurance**

Name of Insurance Co: ______________________________ (Circle) PPO, HMO, POS

Name of Subscriber: ______________________________

Coordination of Care? ❑ **Yes** ❑ **No**

***Do you want your Clinician to communicate with your Primary Care Physcian (PCP)?**

(PCP means your Family Doctor, Pediatrician, or Internist; this will require written authorization)

If you check this box, you will also need to sign a Release of Information Form giving your clinician legal permission to speak with others.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW:

I give permission to my clinician and their billing staff to send required information to my insurance company and /or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as co-pays, deductibles, and non-covered services are my responsibility to pay. **I understand there may be a $110.00 fee if I fail to give a 24 hr notice for cancellation of my appointment.** I understand that my insurance or EAP does not cover the cost of missed sessions.

If I indicated above that I approve for my clinician and their billing staff to communicate with me via phone or E-mail, by my giving my signature, I understand that I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above. I understand that there is an inherent risk when using technology because confidentiality cannot be guaranteed.

Signed: ____ Date: _____/_____/_____