REGISTRATION FORM

(Please Print)

Today's date:	Email Address:

CLIENT INFORMATION

Client's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no. (**optional**):	Home/Cell phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose office because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Website

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and picture ID to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home/Cell phone no.: ( )

Is this person a Client here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this Client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Tricare	❑ Medicaid	❑ Blue Cross/Shield	❑ Cigna	❑ Aetna

❑ ValueOptions	❑ Ceridian EAP	❑ ComPsych EAP	❑ Medical Mutual of Ohio (Carolina Care Plan)	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

ADDITIONAL INFORMATION FOR PARENT/ LEGAL GUARDIAN

Name of Parent/Guardian:	**Name of non-custodial Parent/Legal Guardian (if parents are divorced)**.	If a grandparent/family member/someone else is the Legal Guardian, please supply us with a copy of the Court-Order.	Guardian(s) will be notified if insurance **does NOT** pay.

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to Client:	Home/Cell phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize BAKERS Counseling Services, LLC or insurance company to release any information required to process my claims.

Client/Guardian signature *Date*