SYMATREE

CLIENT REGISTRATION & CONTACT INFORMATION

Today's Date: _____

Client Name: _____
First Middle Last

Address: _____
Street

_____
City State Zip

Home Phone: _____ Cell Phone: _____

I prefer to be contacted at (check all that apply, and number by preference): Home_____ Cell _____

Date of Birth: _____ Age: _____

Social Security Number (SSN is used for insurance claim purposes): _____

If Client is a child, please list parent/guardian information.
Name: _____ Relationship to Child: _____
Address & Phone Number if different from above: _____

Emergency Contact Information (If a parent/guardian is completing this form for a child, do not list yourself):
Name: _____ Relationship to Client: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Employer (if applicable):_____

Insurance Carrier: _____

Insurance Phone Number: _____

Insurance Policy Number: _____

Insurance Group Policy Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number (SSN is used for insurance claim purposes): _____

For your benefit, please call your insurance company to determine the outpatient mental health coverage available to you.

I authorize the release of any information necessary for the processing of my insurance claims.
I authorize payment of insurance benefits directly to the provider for services rendered.
I understand and agree that I am responsible fully for complete payment of services rendered, including payment not covered by insurance.

_____
Signature of Client (or parent/guardian/representative) Date