kp counseling
REGISTRATION FORM

CLIENT INFORMATION

Date of Registration_____ Referred By_____

Client Name_____ Sex_____ Birthdate_____ Age_____

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____ Social Security #_____

Phone number you want used for courtesy appointment reminder call _____

Email address_____ ☐ check if you would like to receive our newsletter.

Employer _____ Work Phone_____

Employer Address_____ City/State/Zip_____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Student Status: ___Full Time ___Part time ___Not a Student

Emergency contact_____ Relationship _____ Phone _____

BILLING INFORMATION *(Please complete if person responsible is not the client)*

Name of Responsible Party_____ Relationship to Client_____

Address_____ Social Security #_____ Birthdate_____

City/State/Zip_____ Home Phone ( )_____ Cell Phone ( )_____

Employer_____ Employer Address_____

Work Phone ( )_____ City/State/Zip_____

☐ ***Please check if you do not have Medical/Health insurance coverage.***

PRIMARY INSURANCE

Highlighted fields required if primary insured is different than the client *(if you do not have your insurance card we will need the entire section completed).*

Name of Insured_____

Address_____

City/State/Zip_____

Phone ( )_____

Client Relationship to Insured

___Self ___Spouse ___Child ___Other

Insurance Company_____

Insured's Employer_____

Insured's Date of Birth_____

Insured's SS#_____

Insurance ID#_____

Group Number_____

Effective Date of Coverage_____

SECONDARY INSURANCE

Name of Insured_____

Address_____

City/State/Zip_____

Phone ( )_____

Client Relationship to Insured

___Self ___Spouse ___Child ___Other

Secondary Insurance_____

Insured's Employer_____

Insured's Date of Birth_____

Insured's SS#_____

Insurance ID#_____

Group Number_____

Effective Date of Coverage_____

If insured please provide your Insurance Card(s) so we can make a copy of the front and back.

~I hereby authorize release of information necessary to file a claim with my insurance and assign benefits otherwise payable to me to be paid to the provider indicated on the claim form.

~I authorize kp counseling to provide medical records to insurance companies.

~I agree that any fee not covered by insurance will be paid at the time of service including co-pays, co-insurance and deductibles.

~I understand I am responsible for getting pre-authorized from my insurance carrier for my first visit.

~I hereby authorize release of information to the person listed as the Responsible Party under Billing Information above for Financial only.

~I have read and agree to the Client Financial Policy. I understand 24 hour notice is required for any cancellations or I will be billed $150.00. This is not a billable charge to your insurance company. All cancellations must be made by phone. _____(**client must initial**).

~It is my responsibility to notify the office of any changes in my insurance plan otherwise I will be responsible for charges.

~A copy of this signature is as valid as the original.

I have read and understand my responsibilities as a client of kp counseling.

Client Signature _____ **Date**_____

Parent/Guardian Signature *(if applicable)*_____ **Date**_____