kp counseling

Client Registration Form

Client Name: ______ Client#: ______

1, CLIENT INFORMATION

Date of Registration______ Referred By______

Client Name______ Gender______ Date of Birth______ Age______

Address______ City______ State______ Zip______

Phone Number______ Cell Number______

Social Security #______ Email address______

Appointment Reminder Preference (select one): ☐ **Text** ☐ **Phone Call** ☐ **Email**

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partners ☐ Married ☐ Minor ☐ Never Married ☐ Separated ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time ☐ Student ☐ Minor

Employer ______ Work Phone______

Employer Address______ City/State/Zip______

Emergency contact______ Relationship ______ Phone ______

In case of an emergency, I give permission for the staff at kp counseling to call the person listed above and/or call (911) for medical assistance and to release any information that will allow for proper medical care.

2, RESPONSIBLE PARTY INFORMATION

Responsible Party's Name______ Relationship to Client______

Address______ Social Security #______ Date of Birth______

City/State/Zip______ Phone Number ( )______ Cell Number ( )______

Employer______ Employer Address______

Work Phone ( )______ City/State/Zip______

☐ ***Please check if you <u>DO NOT</u> have Medical/Health insurance coverage.***

3. PRIMARY INSURANCE AND INSURED INFORMATION

Name of Insured______

Insureds Address______

City/State/Zip______

Phone ( )______

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer______

Insured's Date of Birth______

Insured's SS#______

Insurance Company______

Insurance ID#______

Group Number______

Effective Date of Coverage______

4. SECONDARY INSURANCE AND INSURED INFORMATION

Name of Insured______

Insureds Address______

City/State/Zip______

Phone ( )______

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer______

Insured's Date of Birth______

Insured's SS#______

Secondary Insurance Company______

Insurance ID#______

Group Number______

Effective Date of Coverage______

4.EAP INFORMATION

Name of EAP Company______ Phone ( )______

Authorization Number______ Auth Date Range______

Print Client Name______ DOB______

Client Signature______ Date______

Print Parent/Guardian Name (if applicable)______ Date______

Parent/Guardian Signature (if applicable)______ Date______