Patient Registration Information Form

Patient Name: _____ Birthdate: _____

Street Address: _____

City, State, Zip: _____

County:_____

Patient Marital Status: _____ Married _____ Separated/Divorced _____ Never Married _____ Other

Patient Gender: _____ (for insurance purposes)

Patient/Guardian phone: _____

Patient/Guardian email: _____

We communicate via phone and email. Texts are sent as appointment reminders. Please mark below if you do not want to receive a particular form of communication.

☐ Do not send email ☐ Do not leave phone messages ☐ Do not send text appointment reminders

Primary Care Physician: _____ Physician Phone #: _____

Allergies: _____

Emergency Contact(s) Name: _____ Relationship: _____

Phone #: _____ Secondary Phone #: _____

Address (if different from patient's): _____

Email(s): _____

Referral Source: Physician School Employer Family Member Insurance Company Friend Internet Search

Other: _____

Please list the names and ages of other people living in the home _____

_____

Reason for Appointment: Please check the primary reason(s) for which you have requested this appointment:

☐ difficulty adjusting to a change or transition in your life
☐ difficulty at work
☐ difficulty at home
☐ difficulty at school
☐ social/peer concerns
☐ relationship/family concerns
☐ career struggles
☐ job performance
☐ academic/learning struggles
☐ stress management
☐ self-esteem concerns
☐ loneliness
☐ sleep concerns
☐ attention, focus, memory
☐ anxiety, fear, or worry
☐ mood/depression
☐ irritability
☐ fidgety/hyperactive
☐ Other _____

_____

Patient Insurance Information

(only complete if choosing to submit claims to insurance)

Primary Insurance Carrier (if applicable): _____

Primary Insurance Policy ID#: _____ Group #: _____

Primary Insurance Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's Address (if different from patient's): _____

Policy Holder's Phone Number (if different from patient's): _____

Policy Holder's Employer: _____

Secondary Insurance Carrier (if applicable): _____

Secondary Insurance Policy ID#:_____ Group #:_____

Secondary Insurance Policy Holder's Name:_____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's Address (if different from patient's): _____

Policy Holder's Phone Number (if different from patient's): _____

I authorize Christy Pulsford, GrowthINsight Counseling LLC, and Simple Practice to provide my insurance company or EAP with all information requested by the company. I authorize my insurance company or EAP to reimburses GrowthINsight Counseling LLC Christy Pulsford directly for the services provided. I will self-pay for all services and fees charged which are not assigned a CPT code, or not covered by my insurance plan or EAP plan, and all claims denied by my insurance company or EAP. I will pay all fees charged for appointments missed, cancelled, changed or arrived too late without 24-hour notice. I understand that if GrowthINsight Counseling LLC Christy Pulsford is not a preferred provider for my insurance company, I will be using out-of-network benefits. I will be seeking reimbursement myself from my insurance company and authorize GrowthINsight Counseling LLC Christy Pulsford and Simple Practice to assist by providing superbills and clinical information needed to seek reimbursement for services provided. I will pay my provider directly for all services at the time services are rendered.

_____ _____/_____/_____

Name of Patient/Client (please print) Date of Birth

_____ _____/_____/_____

Signature of Patient/Client or Parent/Legal Guardian Date Signed