CLS Counseling
Clarity, Learning, Support

Registration Form

Client Name:________________________________ Chief Concern(s) to seek Counseling:_________________________

Address:_________________________________ City : _________________________State: ______ Zip: ___________

Email:____

Home Phone: (   ) ______________________ Cellphone: (   ) ________________________

Preferred method of contact: Email   Home Phone   Cellphone
______Initial here to authorize texting as a method of contacting you

Gender: Male Female Other-Explain______________ Please Circle: Single / Married / Widowed / Divorced /Minor

Date of Birth: ______________ Driver's License # :______________________ SSN: ________________________

Religious preference:_______________ Occupation:____________________ Employer:____________________

Spouse/Partner's name: ___________________________ Guardian name (if Minor)__________________________

Children/Age(s)____

Emergency Contact Name _______________________ Relationship ________________Phone (   )_____________

Referred By: ____

Primary Care Physician Name:_____________________________________ Phone #:(   )____________________

Information of the Responsible Party or Insurance Holder

Name: _____________________________ DOB:_________________ Relationship to patient: __________________

SSN:______________________________   Phone (   ) __________________

Address:_________________________________ City : _____________________State: _______ Zip: ___________

Employers Name:_______________________ Phone (   ) ___________________

Address:_________________________________ City : _____________________State: _______ Zip: ___________

Insurance Information (BCBS/BCN-We are awaiting approval for additional insurance providers)
CLS Counseling will not automatically directly bill your insurance company but is able to provide you with a statement to submit, if you so desire. Health insurance companies most often require a diagnosis in order to pay for counseling sessions. Many times, a mental health diagnosis is not warranted, and would be unethical to submit. Further, a mental health diagnosis remains a permanent part of personal medical records. In many cases, avoiding a mental health diagnosis is in the best interest of the client.

Enrollee Name : ___________________________ Enrollee ID # : ____________________ Group#____________________

Payment Options: Cash, Check, Visa, Master Card, Discover & American Express. Payment is due to the therapist at the beginning of each appointment.

Financial Agreement
I hereby give lifetime authorization for payment of insurance benefits to be made directly to LPC Associates at CLS Counseling for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and responsible attorney fees. There is a "Returned Check" fee of $25 in the event that a check does not clear. I hereby authorize this heath care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

____   ____________________
Signature   Date

FOR OFFICE USE ONLY:
Insurance Card Copied   Drivers License Copied