



CLARITY PSYCHOLOGICAL  
SERVICES LLC



## REGISTRATION FORM

First Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Middle Initial \_\_\_\_\_ Gender \_\_\_F\_\_\_ M\_\_\_ Non-Binary  
Last Name \_\_\_\_\_ \_\_\_ Prefer not to answer  
Nickname/Preferred Name \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_  
\_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_

### **Emergency Contact**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Permission to Contact in the event of an  
Emergency \_\_\_ Yes \_\_\_ No

### **Insurance Information**

Name of Carrier \_\_\_\_\_ Secondary Information  
Name of Carrier \_\_\_\_\_  
Subscribers Name \_\_\_\_\_ Subscribers Name \_\_\_\_\_  
Subscribers Birthdate \_\_\_\_\_ Subscribers Birthdate \_\_\_\_\_  
Policy Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Check here if no insurance or prefer to pay by cash

*The information provided in this document is true to the best of my knowledge.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date