Gill Counseling & Consulting, LLC
2025 East Main Street, Suite 200
Richmond, Virginia 23223

Date: _____

Client Registration Please provide the following information:

Name: _____ Male Female

Date of Birth: _____

Address: _____ Age: _____

City/State/Zip: _____ SS#: _____

Phone Numbers: _____ _____
(Primary) (secondary)

E-mail address: _____

Emergency Contact: Name: _____ Phone: _____

Payment Information
Payment is due at the time service is provided. My services are generally at least partially reimbursed by insurance plans. However, you are ultimately responsible for payment of services.

You expect sessions to be covered under: Insurance◯ EAP◯

Insurance: ***Complete only if you do not have your insurance card with you OR you are covered under another person's insurance policy***
Each year, deductibles must be paid before your insurance will begin paying for these sessions. I will make a copy of your insurance card(s).
Insurance provider: _____

Name of primary insured individual if not yourself: _____

Birthdate of primary insured if not yourself: _____

A secondary insurance usually covers all co-payments. Do you have a secondary insurance? Yes No

If yes: Insurance provider: _____ ID#: _____

Group #: _____

EAP (Employment Assistance Program)

EAP Provider: _____

Authorization #: _____

sessions approved: _____

After EAP sessions have been utilized, you may continue treatment using your insurance benefits. It is your right to continue working with me or to be referred to another provider. These issues will be discussed as you near the end of your approved EAP sessions.

Under EAP contracts, I am not allowed to bill for missed sessions. However, in the interest of maintaining a therapeutic relationship based on mutual respect, notice is very much appreciated.

Diagnosis code(s) for insurance billing: _____