Empowering Relief Counseling, PLLC
*Affirm * Connect * Empower*

5814 S 900 E
Murray, UT 84121
(p) 385-800-3272 * (f) 385-800-3260
http://ercounseling.com

REGISTRATION FORM

please fill out as completely as possible

If you are not the client, please complete the following:

Name:	Relationship to the Client:

CLIENT INFORMATION

Legal Name:	Preferred Name:	Today's Date:	Date of Birth:	
Gender*:	Pronouns:	Sexual Orientation:	Race / Ethnicity:	Age:

CONTACT INFORMATION

Address:	City:	State:	Zip:

Telephone #: Okay to leave a message with business name? ☐ Y ☐ N Okay to text? ☐ Y ☐ N	Email Address: Okay to email identifying business name? ☐ Y ☐ N	I would like a reminder of my appointments (check all that apply): ☐ Text ☐ Email ☐ None
Please briefly describe the problem(s) for which you are seeking services:		

Please provide us a copy of the front and back of your photo identification prior to your initial evaluation.

EMERGENCY CONTACT

Name:	Telephone #:	Relationship to Client:

☐ Same as client contact information above.

Address:	City:	State:	Zip:

OTHER INFORMATION

Primary Care Physician (PCP):	PCP Telephone #:
Food / Drug Allergies: ☐ None	Medications: ☐ None
Employer:	Employer Telephone #:

FOR CHILDREN (under 18 years of age) **& ADULTS WITH GUARDIANSHIP**

Parent / Legal Guardian:	Type of Custody: ☐ N/A ☐ Joint ☐ Sole ☐ Physical ☐ Legal ☐ No Custody ☐ Other ____________________ Authorized to make medical decisions on child's behalf? ☐ Y ☐ N

☐ Same as client contact information above.

Address:	City:	State:	Zip:

If more than one legal guardian/parent, please complete the following section:

Parent / Legal Guardian:	Type of Custody: ☐ N/A ☐ Joint ☐ Sole ☐ Physical ☐ Legal ☐ No Custody ☐ Other ____________________ Authorized to make medical decisions on child's behalf? ☐ Y ☐ N

☐ Same as client contact information above.

Address:	City:	State:	Zip:

INSURANCE INFORMATION

Would you like us to bill insurance on your behalf? ☐ Y ☐ N If yes, please complete the following section:

> *Regardless of how you answered questions about gender, insurance companies often designate a client's sex as either 'male' or 'female' in their billing systems. There may be delays or issues with coverage if claims we submit on your behalf do not match the sex designation on insurance records. If you are intersex or transgender and have questions about sex designations and insurance coverage, please let your care provider know.

Primary Insurance

Insurance Carrier:	Member ID#:	Group ID#:	Copayment/Coinsurance:	Deductible:

For insurance purposes only, please select the sex category we should use when submitting claims to the insurance company*: ☐ Male ☐ Female

Client is Primary Insured: ☐ Y ☐ N If no, please complete the following section:

Primary Insured

Name:	Relationship to Client:	Date of Birth:

☐ Same as client contact information above.

Address:	City:	State:	Zip:

Secondary Insurance ☐ N/A

Insurance Carrier:	Member ID#:	Group ID#:	Copayment/Coinsurance:	Deductible:

Client is Primary Insured: ☐ Y ☐ N If no, please complete the following section.

Primary Insured

Name:	Relationship to Client:	Date of Birth:

☐ Same as client contact information above.

Address:	City:	State:	Zip:

Please provide us a copy of the front and back of your insurance card(s) prior to your initial evaluation.

How did you hear about us? ____