CLIENT REGISTRATION FORM

PRAIRIE COUNSELING SERVICES
1460 W. Main Street, Sun Prairie, WI53590

CLIENT INFORMATION

Name: _____
Date of Birth: _____ Age:_____
Address: _____
_____
City/State/ZIP: _____
Employer: _____
EMAIL: _____

Home Phone: ( )_____
Cell Phone:( )_____
Work Phone:( )_____
Social Security #_____
Male: ____ Female: ____ Marital Status:_____
Spouse: _____ Date of Birth: _____
How were you referred to us: _____

BILLING INFORMATION (RESPONSIBLE PARTY OR INSURANCE CARD HOLDER IF OTHER THAN SELF)

Name: _____
Date of Birth: _____ Male: ___ Female: ____
Address: _____
_____
City/State/ZIP: _____

Home Phone: ( )_____
Cell Phone: ( )_____
Work Phone: ( )_____
Social Security #_____
Employer: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Name:_____
Address:_____
_____
_____
Phone #: _____
ID or Subscriber #: _____
Group #: _____
Name of Insured: _____

SECONDARY INSURANCE COMPANY

Name:_____
Address: _____
_____
_____
Phone #: _____
ID or Subscriber #:_____
Group #: _____
Name of Insured: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and psychotherapy benefits to which I am entitled (including Medicare, private insurance and/or other health plan benefits to Prairie Counseling Services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original copy. I understand that I am financially responsible for all charges. I hereby authorize said assignee (Prairie Counseling Services) to release all information necessary to secure payment on my behalf.

_____ _____
Signature of Client (14 years or older) Date

_____ _____
Signature of Responsible Party (if client is a minor) Date

OTHERHOUSEHOLD OR FAMILY MEMBERS:

Name: _____Relationship: _____ Date of Birth: _____
Name: _____Relationship: _____ Date of Birth: _____
Name: _____Relationship: _____ Date of Birth: _____