Registration Form

Highland Park Counseling Associates, LLC

Date_____

DX Code_____

Individ Therapist _____

DB Group ID _____

Patient Information

Patient Name (Print)_____ **Date of Birth** _____
Last Name First Name Initial

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Work Phone _____

Soc. Sec. #_____Emergency Contact_____ Emerg Phone _____

Sex: □ Female □ Male Age_____ Marital Status: □ Single □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Other

Employer _____ Occupation_____

E-mail Address: _____ Referred by: _____

Primary Insurance

Primary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____Group/Plan #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____Relationship _____
Last name First Name Initial

Address_____City_____State_____Zip_____**Date of Birth**_____

Soc. Sec#_____Employer_____

Secondary Insurance

Secondary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____Group/Plan #_____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name_____Relationship _____
Last name First Name Initial

Address_____City_____State_____Zip_____**Date of Birth**_____

Soc. Sec#_____Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____Relationship _____

Address_____Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship To Patient Date