Client Registration
Highland Park Counseling Associates; LLC

Name:_____ **DOB** _____
First Middle Initial Last
Address_____**City**_____**State**_____**Zip**____
Email address: _____**Gender identification**_____
Cell phone _____ **Preferred phone?** __Yes __No (Please check one)
Home/other phone _____ **Preferred phone?** __Yes __No (Please check one)
Emergency Contact: Name_____**Phone** _____

Please list your primary and secondary insurance info below (ID, Group #s, Contact #s.

_____

Policy Holder Information: (if client is not the policyholder)
Name_____**Relationship**_____**DOB**_____
Address_____**City**_____**State**_____**Zip**_____
Responsible party (Where should the patient's portion of the bill be sent, if not to the patient?)
Name/Address: _____
Do you prefer to receive your monthly statement via __Email or __ USPS mail (Check one/ both) **If different than the email or mailing address listed above, please indicate here:**

_____

Please call Janet Schultz (651) 730-1990 or Judy Larson (952) 934-0678 with your insurance information. We ask that you have them verify your current insurance benefits including any out of pocket expenses you will incur such as deductible and coinsurance amounts. They will relay that information directly to your assigned psychotherapist.
Please place a checkmark here____if you have done so.

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 my provider and Highland Park Counseling Associates, LLC to release all information necessary to secure the payment of benefits and to mail billing statements. I authorize the use of this signature on all insurance submissions:

Printed name of client_____

Signature of client_____ Date_____

Signature of legal guardian (if minor)_____Date_____