

PATIENT REGISTRATION

Patient Name: _____ SS #: _____

Street Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Marital Status: S M W D SEP

Home Phone: _____ Office Phone: _____

Referred By: _____

Spouse's Name: _____

Spouse's Employer/Address: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____

Have you had same or similar illness? _____. If so, when was first date of treatment or diagnosis? _____. If applicable, when were you first unable to work due to condition? _____. Have you been hospitalized due to this condition? _____. If so, please list date or dates. _____. Are you now under the care of a psychiatrist or therapist? _____. Diagnosis (if none given, please indicate) _____.

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Phone #: _____

Employer Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Occupation: _____

INSURED PERSON (IF NOT PATIENT)

Name: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____ Employer Name: _____

Medicaid # (if applicable): _____

Medicare # (if applicable): _____

Primary Insurance Name: _____

ID #: _____ Group #: _____ Phone #: _____

Secondary Insurance Company Name: _____

ID #: _____ Group #: _____ Phone #: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date: _____ Signature: _____

I hereby authorize RUSSELL COUNSELING SERVICES to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made directly to RUSSELL COUNSELING SERVICES.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date: _____ Signature: _____

Patient, Parent or Gauardian