

Branch Counseling, Debra O'Berry
REGISTRATION FORM

INTAKE DATE: _____ REFERRED BY: _____

PATIENT NAME: _____ **Date of Birth:** _____ **Age:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ EMPLOYER: _____

PHONE: _____ CELL: _____ WORK PH: _____

SEX: Female Male **MARITAL STATUS:** Single Married Divorced

RESPONSIBLE PARTY: _____ **Date of Birth:** _____

ADDRESS: _____ SS# _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____ WORK PH: _____

INSURANCE #1: _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER: _____ **PHONE #:** _____

INSURED DOB: _____ **EMPLOYER:** _____

INSURANCE #2: _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER: _____ **PHONE #:** _____

INSURED DOB: _____ **EMPLOYER:** _____

EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____

PRIMARY CARE DR: _____ **PH# :** _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY)

In order to submit a claim for payment to us for services covered under your policy, I must have authorization to release medical information to your insurance company and to my billing company for paper & electronic billing. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized Branch Counseling and her billing company to file for benefits on my behalf for mental health services received. Insurance payments shall be made directly to Branch Counseling. If I have Medicare insurance, I authorize Branch Counseling to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by Branch Counseling by written request. I consent to Branch Counseling to provide professional services to me.

SIGNATURE _____ **DATE** _____