ABDO COUNSELING AND CONSULTING, PLLC

REGISTRATION FORM

(Please Print or download and complete)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home/cell phone no.: ( ) Can we leave a message/text?
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )

Referred to practice by: (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Psychology Today ❑ Other

Email address:

INSURANCE INFORMATION

(Please bring a copy of your insurance cards with you to first session)

Person responsible for bill:	Birth date: / /	Address (if different):	Home/cell phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑Financial arrangement ❑ Self Pay

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize Abdo Counseling and Consulting, PLLC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*