Fee: _____

Date: _____ **Therapist:** _____

Diagnosis Code: _____

Client's #: _____

PATIENT REGISTRATION

Patient Information:

_____ _____ _____

First name **M.I.** **Last name**

DOB: _____/_____/_____ **Gender**: M / F **Marital Status**: S M W D

Address:_____

City: _____ **State**:_____ **Zip Code**:_____

Social Security #: _____/_____/_____

Phone: (home): (_____)_____ (cell): (_____)_____

Employer:_____ (work): (_____)_____

Email: _____

Insurance Information:

Insurance Company: _____ Policy #/ID: _____

Person responsible for payment (circle one): Self, Spouse, Parent, Other: _____

Responsible Party: ***If person other than patient is responsible for insurance payment***, please complete:

Name: _____SSN: _____DOB: _____ /_____/_____

Address: _____

Employer Name:_____

Emergency Contact (nearest relative or friend not living with you):

Name: _____Relationship to you: _____

Address: _____

Phone: _____

ASSIGNMENT OF BENEFITS

I hereby authorize The Christian Counseling Center of First Presbyterian Church to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign to the therapist all payments for medical services rendered and **all major medical benefits**. I recognize that insurance quotes given to me are information that FPCCC obtained from my insurance company and that this information does not guarantee payment. I recognize that payment will be determined when the claim is processed and that I am responsible for any fees the insurance company does not pay.

I understand that I am financially responsible for all fees incurred, regardless of whether insurance pays.

_____ _____

Patient/Insured Date