



MARRIAGE & FAMILY THERAPY ASSOCIATES, LLC REGISTRATION FORM

This information is requested to register you as a client. The information is confidential and will be placed in your file.

Client's Name: _____ Date: _____

Date of Birth of Client: (m/d/y) _____ Social Security No: _____

If client is under 18 years old name of parent or guardian _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (Cell) _____

May your therapist or our office manager call your home and leave a message? Yes No
May your therapist or our office manager call your work and leave a message? Yes No

Employer: _____ Emergency Contact Number _____

Spouse/Partner _____ Date of Birth _____

Relationship Status: Single__ Married__ Partnership__ Divorced__ Separated__ Widowed__

How did you first hear of us? Please check one **Yellow Pages** **Internet** **Insurance Co**
 Health Care Provider **Friends/Relatives**

Primary Insurance Information

Private Pay

Name of insurance company: _____

Name of policy holder: _____ Relationship to client: _____

DOB _____ ID No. _____ Group No: _____

Employer: _____

Secondary Insurance Information

Name of insurance company: _____

Name of policy holder: _____ Relationship to client: _____

DOB _____ ID No. _____ Group No: _____

Employer: _____

**Please provide a photocopy of your mental health benefits card.
COPAYMENTS are required at the time of each session.**

WE ACCEPT CHECKS OR CASH ONLY NO DEBIT OR CREDIT CARDS

For billing purposes only, in the current calendar year have you seen another therapist? Yes No If so, please estimate how many sessions you have had _____

Have you obtained benefits/authorization for individual therapy from your insurance company? Yes___ No___

Date called: _____ Insurance Phone Number _____

Contact Person: _____ Effective Date of policy _____

Type of policy _____

Maximum Visits allowed: _____/year Co-pay:\$_____ or % _____/session

Deductible _____ Amount already met _____

Is Prior Authorization required? Yes___ No ___ If yes Authorization No. _____

Number of Visits Authorized _____ Dates of Authorization _____

Any restrictions on policy _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it and ask questions.

Name _____ Birth date _____

Signature _____

Date _____