



# MARRIAGE & FAMILY THERAPY ASSOCIATES, LLC

## REGISTRATION FORM

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

Patients Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: (M/D/Y) \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Spouse/Partner \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Employer: \_\_\_\_\_ Emergency Contact Number \_\_\_\_\_

Relationship Status: Married\_\_ Single\_\_ Divorced\_\_ Separated\_\_ Partnership\_\_ Widowed\_\_

May your therapist or our office manager call your home and leave a message? (Please circle one) Yes No  
May your therapist or our office manager call your work and leave a message? (Please circle one) Yes No

### **Primary Insurance Information**

**Private Pay**

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.**

**Have you obtained authorization from your insurance company? Yes\_\_ No\_\_**

Date called: \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Contact Person: \_\_\_\_\_ Authorization No: \_\_\_\_\_

Maximum Visits allowed: \_\_\_\_\_/year Co-pay: \$\_\_\_\_\_/session

Deductible Amount \_\_\_\_\_ Amount already met \_\_\_\_\_ (over)