

CLIENT REGISTRATION

Client name _____ Chart number _____

Address _____ Cell phone _____
(street)

_____ Home phone _____
(city) (state) (zip)

Birth date _____ Age _____ Gender _____ Work phone _____

Employer or school _____ Occupation or grade/major _____

Employer/school address _____

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Financial responsibility: If you intend to use insurance, this should be the policy holder. Bring your insurance cards with you, and call the number on the back of your card before your first session to confirm co-pay / pre-authorization.

Name _____ Self Spouse Parent Other _____

Address _____

Birth date _____ Age _____ Gender _____ Insurance Member Number _____

Insurance plan _____ Co-pay _____ Authorization number _____

Employer/school address _____

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In case of emergency:

Person to contact _____ Relationship to client _____

Address _____ Home phone _____

_____ Work phone _____

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As appropriate, information about another person(s):

Spouse Partner Custodial Parent(s) Foster Parent(s)

Name(s) _____ Legal Guardian Other _____

Address _____ Home phone _____

_____ Work phone _____

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Consent and payment authorization:

I hereby authorize the release of any medical information necessary to process insurance claims.
I also accept full responsibility for payment of services rendered by A Center for Change and Growth.

Signature: _____ Date _____

Client Parent (of dependent child) Legal Guardian