HERON RIDGE ASSOCIATES REGISTRATION INFORMATION

PAYMENT EXPECTED AT TIME OF SESSION. MAKE CHECKS PAYABLE TO: HERON RIDGE ASSOCIATES

Client Information

Date_____

Name: _____Address: _____
Street *City/State* *Zip Code*

Home Phone: _____ Cell: _____ Birthdate: ___/___/___ New Client? Y / N Height:_____Weight:_____

Referred by:_____ If EAP Auth #/ company:_____/_____ Client's Employer:_____

Marital Status: S/M/D/W Sex: M / F Social Security #:_____/_____/_____ Maiden Name:_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Emergency Contact Address:_____

Insurance Information: Please provide insurance card and driver's license for therapist to copy. **I understand it is my Responsibility to check and verify my own insurance benefits.** The Staff of Heron Ridge Associates does not do this for me**.**

Primary Insurance: _____ Policy#:_____ Subscriber:_____

Group#:_____ Relationship to Client:_____ IOP : ( ) No ( ) Yes

Subscriber Employed By:_____ Subscribers Birthday:____/_____/_____ Policy Effective Date:_____

Co-Pay Requirements:_____ Deductible: ( ) None ( ) Yes, amount_____

Secondary Insurance: _____ Policy#:_____ Subscriber:_____

Group#:_____ Relationship to Client:_____ IOP : ( ) No ( ) Yes

Subscriber Employed By:_____ Subscribers Birthday:____/_____/_____ Policy Effective Date:_____

Co-Pay Requirements:_____ Deductible: ( ) None ( ) Yes, amount_____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage through_____
And assign directly to Heron Ridge Associates or my independent therapist_____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I do hereby authorize them to release all information necessary to secure payment of appropriate benefits. I authorize the use of this signature on all insurance submissions, and or credit card charges as applied.

Please check one:

_____Release any applicable behavioral healthcare information to my primary care physician (PCP)

_____Release only any medication prescribed by Heron Ridge Associates doctors to my PCP

_____I DO NOT give authorization to release any information to my PCP

_____

Responsible Party Signature ***Relationship to Client*** ***Date Signed***

Printed Name ***Employer*** ***Phone Number***

**********Office Use Only**********

Case #:_____ Location Services:_____ Therapist:_____ DX:_____

Authorization #:_____ Visits #:_____ Dates, From:_____ To: _____