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*

Maiden Name:_____ Responsible Party (if client under 18 yrs):_____Employer:_____

Home Phone: _____ Business: _____ Cell: _____ Birthdate: _____

New Client? Y / N Referred by:_____ Marital Status: S/M/D/W Sex: M / F Height:_____ Weight:_____

Social Security #: _____-_____-_____ Email Address:_____ Client's Employer:_____

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: _____ Contract#:_____ Subscriber:_____

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

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

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***

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

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

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

Insurance Contact for Authorization Name:_____ Time/Date of Contact:_____