

BRIDGET GWINNETT, MS, LPC, NCC

Licensed Professional Counselor

REGISTRATION FORM

Date: _____	Referred by: _____		
Name: _____	_____	_____	
(last)	(first)	(middle)	
Address: _____	_____	_____	_____
(street)	(city)	(state)	(zip)
Phone # (home) _____	(work) _____	X	(cell) _____
OK to call? Y N	OK to call? Y N		OK to call? Y N
Sex: M F	Birthdate: _____	Age _____	Marital Status: M S D Partnered
SSN: _____	Emergency Contact (Name & Ph #): _____		

INSURANCE INFORMATION

Primary

Secondary

Insurance Plan Name: _____
Insured ID #: _____
Group Policy #: _____
Policy Holder's Name: _____
Birth date: ____/____/____
SSN ____-____-____
Mail Claims to: _____

Employer: _____

Insurance Plan Name: _____
Insured ID #: _____
Group Policy #: _____
Policy Holder's Name: _____
Birth date: ____/____/____
SSN ____-____-____
Mail Claims to: _____

Employer: _____

Client Relationship to Insured: Self _____ Spouse/Partner _____ Child _____

Is Client a Student? Y N Part-time _____ Full-time _____ School _____

If Client is a child, who has primary legal custody? _____

Spouse/Parent Names: _____ Ph # _____
_____ Ph # _____

Address if different from Client: _____

Initial Below:

_____ I consent to treatment with Bridget Gwinnett, MS, LPC, NCC.

_____ I do/do not (circle one) consent to release of information to my primary physician.

_____ I authorize the release of information for the purpose of insurance billing and verification. I agree to make any co-insurance payments required by my policy at the time of services. I understand that I may be billed for sessions that are not cancelled within 24 hours. I also understand that a fee will be added to any accounts referred to a collections agency due to non-payment.

Guarantor's Signature: _____ Date _____