Client Registration Form

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Today's Date: _____

Client Name: _____ D.O.B: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Social Security #: _____

Telephone Numbers

(Home): _____ (Cell #1): _____

(Work): _____ (Cell #2): _____

- Please indicate with an * which numbers we m ay leave a message

Email Addresses

Email #1: _____ - belongs to: _____

Email #2: _____ - belongs to: _____

Parent / Guardian Contact Information (if applicable)

Parent / Guardian (address if different from child's): _____

Parent / Guardian (address if different from child's): _____

Other Providers' Information

Primary Care Physician: _____

Phone #: _____ Fax: _____

	Name	Service	Telephone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

How were you referred to me?

☐ Insurance Company ☐ Yellow Pages ☐ Mailing

☐ Friend ☐ Therapist ☐ Internet search

☐ Other

Comments, and who may I thank you for referring you (with address if possible)?:

_____

Over, complete reverse

Financially Responsible Party

Name: _____ Relationship to client: _____

Phone (if different from above): _____ Address (if different from above):

Which payment type: _____

☐ Private pay ☐ Out of Network

☐ Insurance ☐ Other 3rd party payer, describe:

Insurance Information

Policyholder Full Name: _____ D.O.B: _____

Social Security #: _____ Employer: _____

Insurance Plan: _____ Group: _____

Policyholder ID #: _____ Phone # for benefits: _____

Identified Client ID #: _____

Claims Billing Address:

_____

Co-pay amount: $ _____ Co-insurance: $ _____

Deductible amount: $ _____ met? ☐ Yes ☐ No If No, remaining deductible amount: $ _____

UR Contact Name: _____ UR Contact Phone #: _____

Extension #: _____ Fax #: _____

Insurance Authorization #: _____ # of sessions authorized: _____

If applicable, authorization period, from _____ (date) to _____ (date)

Is there a secondary insurance? ☐ Y ☐ N

Insured's Name: _____ Insured's Social Sec. #: _____

Insured's D.O.B.: _____ Group/Policy #: _____

Emergency Contact People

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

(By filling in emergency contact person information you are authorizing Ozgur Akbas to contact this person in an emergency.)

Client Authorization:

I understand that I am fully responsible for any fees for professional services provided to me or my dependents. If I am using my insurance, my signature below authorizes Ozgur Akbas to submit claim forms for me directly to my insurance company, but does not guarantee payment of claims. I authorize the release of any medical or other information required by my insurance company to receive authorization for services or to process claims for services to me or my dependents.

Signature: _____ Date: _____

Signature: _____ Date: _____

*Internal Use Only

Fee:

Diagnosis: