

Client Registration Form

Ozgur Akbas

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Helping Individuals, Couples & Families Achieve Balance



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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 may 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)?:

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: