Registration Form

Therapist Name: _____

Client Information:

Last Name _____ First _____ MI_____

Date of Birth ____/____/____ Sex: M / F

Social Security #_____ Relationship status _____

Address _____ City_____ State & Zip_____

Employer _____
Occupation _____

Home phone #_____
Work Phone #_____
Cell Phone #_____

Emergency contact _____
Phone #_____

___I authorize my therapist to contact the above named emergency contact in case of an emergency. (please initial) _____

PLEASE COMPLETE THIS SECTION IF CLIENT IS A MINOR

Parent(s)/Guardian(s): _____MI_____
Date of Birth ____/____/____ Sex: M / F
Social Security #_____ Relationship to client _____
Address _____ City_____ State & Zip_____
Employer _____ Occupation _____
Home phone #_____ Work Phone #_____
Cell Phone #_____

Payment of Fees (All Clients)

Your initial individual evaluation fee is $___130_____
Your initial couples and family evaluation fee is $___140_____
Your individual 60 minute session fee is $__130_____
Your couples and family 60 minute session fee is $__140_____
Your individual 45 minute session fee is $__100_____
Your couples and family 45 minute session fee is $__110_____

The ultimate responsibility for payment on your account is the client's or the client's parent/guardian. We do not accept responsibility for collection of your claim or negotiating a settlement on a disputed claim.

When necessary to cancel an appointment, please do so at least 24hrs in advance. Please leave a cancellation message directly in the confidential voice mail of your therapist. A client or client's parent/guardian is personally responsible for the professional fee when an appointment is missed and/or not properly canceled, except in

extenuating circumstances. Your therapist reserves the right to determine whether reasons for cancellation warrant waiving fees for missed session. Insurance will not reimburse for missed appointments.

All payments are due on the date of session. Your therapist reserves the right to recoup owed monies through the use of collection agencies or the courts.

I understand and agree to the payment conditions described above.

Client Signature (or parent/guardian) _____ Date _____

PLEASE COMPLETE THIS SECTION IF USING INSURANCE (clients of John Migueis, LCSW Only)*

Primary Insurance Company _____
Effective Date of Coverage _____
Insurance Co. Address _____
Circle type of coverage: Family / Individual

Group # _____ Subscriber # _____
Subscriber SS # _____

Name of Policyholder _____
DOB of Policyholder _____/_____/_____
Relationship to client _____

Address of Policyholder (if different from client)
_____
Employer _____ Occupation _____

***If using insurance, please give your card and the policyholder's photo ID to your therapist or the receptionist so copies can be made for our billing office.**

ASSIGNMENT OF BENEFITS - PLEASE COMPLETE THIS SECTION IF USING INSURANCE (clients of John Migueis, LCSW Only)*

I hereby authorize John Migueis, LCSW to bill my insurance company directly. I hereby authorize my insurance carrier to make payments directly to John Migueis, LCSW for psychotherapy services. I accept personal responsibility for the deductible amount and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and that they be accepted as valid as the original.

Client Signature (or parent/guardian) _____ Date _____