CLIENT REGISTRATION – LEGACY PSYCHOLOGICAL SERVICES, LLC

Client Name (First, MI, Last) | Sex ○ Male ○ Female | Date of Birth | Age | Social Security #

Address (Street, Apt.No.) | City | State | Zip

Home Phone | Work Phone | Cell Phone/Pager | Employer / Occupation | School attending / grade level

Marital Status: ○ divorced ○ married ○ widowed ○ separated ○ single

Who referred you here?

Emergency Contact

Phone

PAYMENT INFORMATION (Person responsible for payment if different from client)

Name (First, MI, Last,) | Date of Birth | Social Security # | Relationship to client ○ Spouse ○ Child ○ Other

Address (Street, Apt No.)

City | State Zip

Home Phone | Work Phone | Cell Phone/ Pager | Other

Employer Name

Employer Address

City | State | Zip

Primary Insurance Policy Holder (Name as on insurance card ID#) Date of Birth

Primary Insurance Company | Policy ID Number | Group Number

Insurance Claim Address (Street, Suite No.)

City | State | Zip | Phone

Secondary Insurance Policy Holder (Name as on insurance card ID#) Date of Birth

Secondary Insurance Company | Policy ID Number | Group Number

Claim Address (Street, Suite No.)

City | State | Zip | Phone

Legacy Psychological Services, LLC., is hereby authorized to release to the insurance/managed care company or its representative any and all information about the client above including history, diagnosis, and treatment progress. I hereby assign the benefits payable to Legacy Psychological Services, LLC. I have read and agree to the terms outlined on the Consumer Policy Information Sheet.

Legal Signature: _____ Date: _____