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 **Cell Phone/Pager** **Work Phone** **Email Address** **Employer / Occupation**

Marital Status: ○ Married ○ Separated ○ Divorced ○ Widowed ○ Single

Who referred you here?

Emergency Contact:

Phone:

Complete payment information OR provide current copy of insurance card.

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 OR provide current copy of insurance card.

Name on insurance card: **Date of Birth:**

Primary Insurance Company **Policy ID Number** **Group Number**

Insurance Claim Address (Street, Suite No.)

City: **State:** **Zip:** **Phone:**

Secondary Insurance Policy OR provide current copy of insurance card.

Name on insurance card : **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. I have received the Privacy and Protected Health Information brochure that describes how my health information is use and protected.

Legal Signature: _____ **Date:**_ _____ (Revised 2/2022)