

CLIENT REGISTRATION – PEACE OF MIND, INC.

CLIENT’S LAST NAME _____ FIRST NAME _____ INITIAL _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ SEX _____ EMAIL ADDRESS _____

HOME PHONE _____ WORK/CELL PHONE _____ DATE OF BIRTH _____

CLIENT’S SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

GUARANTOR INFORMATION (Please complete if client is a minor)

MOTHER’S NAME: _____ SSN _____

FATHER’S NAME: _____ SSN _____

1. TRICARE: PRIME: _____ EFF.DATE: _____ EXTRA: _____

SPONSOR NAME: _____ SPONSOR RANK: _____

SPONSOR SSN#: _____ SPONSOR DOB: _____

TRICARE AUTHORIZATION #: _____

2. INSURANCE CO.: _____ PHONE#: _____

SUBSCRIBER NAME: _____ DOB: _____

POLICY ID#: _____ GROUP #: _____

SSN#: _____ EMPLOYER: _____

3. MEDICAID _____ RECIPIENT ID#: _____

(Please complete if client is a minor)

NAME OF ADULT CHILD LIVES WITH. _____

WHO HAS LEGAL CUSTODY OF THE CHILD? _____

NAMES OF OTHER PEOPLE LIVING IN THE HOME _____

SCHOOL GRADE _____ NAME OF SCHOOL _____

TEACHER/COUNSELOR NAMES _____ PHONE # _____

PLEASE TURN OVER AND CONTINUE ON BACK SIDE

_____ Clinician

_____ Record #

FAMILY PHYSICIAN _____

ALLERGIES _____

MEDICAL PROBLEMS AND CURRENT MEDICATIONS _____

ISSUES BRINGING YOU TO COUNSELING _____

WHAT YOU HOPE TO CHANGE _____

As a courtesy, we generally call to remind our clients of scheduled appointments. This may cause confidentiality concerns for you and because of this, we would like to give you the opportunity to either request or decline this courtesy call. Please do so by initialing your preference:

_____ PLEASE CALL _____ PLEASE LEAVE MESSAGE _____ DO NOT CALL

WHO REFERRED YOU TO US? _____

MAY WE CONTACT THEM TO EXPRESS OUR GRATITUDE? _____

Providing information on race/ethnicity is voluntary and will be held confidential. The _____ strives to provide services to all families in a culturally sensitive manner. In order to assist us in meeting the needs of our culturally diverse population, we ask that you complete the following section:

PLEASE SPECIFY THE CLIENT'S CULTURAL/ETHNIC GROUP:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Biracial (biological mother): _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> (biological father): _____ |

NAME OF PERSON WE MAY CONTACT IN CASE OF EMERGENCY: _____

ADDRESS: _____

WORK PHONE: _____ HOME PHONE: _____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION OBTAINED DURING EVALUATIONS OR TREATMENT OF THIS CLIENT TO THE INSURANCE COMPANY INDICATED ABOVE WHICH IS NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE PAYMENT OF BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THIS PROVIDER. MEDICARE REGULATIONS MAY APPLY.

Client/Legally Responsible Person's Signature

Date