Client Insurance Registration

Date: ____ File #:____________________

Patient Information

First Name:______________________________ MI.:__________ Last Name:______________________________

Address:______________________________ City:______________________________ST:________ Zip:____________

Home Phone: ( )_______-__________Birth date:_____/_____/_____ Age_______ Sex: M F Marital Status: S M D W

Employer:____________________________ Address: ________________________City: __________ ST:______ Zip:________

Work Status: Full Part Time Retired Student School:______________________________ Full Time Part Time

Guarantor Information (Responsible Party)

First Name:____________________ MI.:____ Last Name:____________________________ S.S.#: ____________________

Address:______________________________ City:______________________________ST:________ Zip:____________

Phone: ( )_______-______________Birth date:______/______/______ Sex: M F Marital Status: S M D W

Employer:____________________________ Address: ________________________City: __________ ST:______ Zip:________

Work Status: Full Part Time Retired Student School:______________________________ Full Time Part Time

Payment & Insurance Information (we will need a copy of your insurance card)

Primary Insurance:____________________ Address:________________________ City:___________ ST:____ Zip:________

Phone: ( )_____-__________ Type: ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name:______________________ Group/Plan #:__________________________ **ID#:**________________________

Policy Holder:______________________________ Birth date:____/_____/____ Relation to Patient: Self Spouse Parent Other

Other Insurance:____________________ Address:________________________ City:___________ ST:____ Zip:________

Phone: ( )_____-__________ **Type:** ( ) Individual ( ) Group ( ) Medicaid ( ) Medicare ( ) Blue Cross ( ) Blue Shield

Group Name:______________________ Group/Plan #:__________________________ **ID#:**________________________

Policy Holder:______________________________ Birth date:____/_____/____ Relation to Patient: Self Spouse Parent Other

Assignment of Benefits, Release of Information & Payment Agreement

I understand that payment is due at the time of service unless other arrangements have been made. I understand that **Spirals Counseling, LLC Lynell Rice Brinkworth, LMFT, QMHP** will be filing my insurance on my behalf. I agree to have the benefits from my insurance assigned to **Lynell Rice Brinkworth, LMFT, QMHP**. I permit **Lynell Rice Brinkworth, LMFT, QMHP** to release any information deemed necessary to any insurance or third party.

I agree that I am responsible for full payment of this account. I agree to be held responsible for all attorney fees and court costs in the collection of this account.

____ ____________________

Responsible Party Date

____ ____________________

Patient Date