CHRISTINE SPERRAZZA
LCMHC, PLLC

Psychotherapy

CLIENT REGISTRATION FORM

CLIENT FULL NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ Can message be left on this phone? YES NO

CELL PHONE: _____ Can message be left on this phone? YES NO

WORK PHONE: _____ Can message be left on this phone? YES NO

GENDER: MALE __ FEMALE __ OTHER __

MARITAL STATUS: SINGLE __ MARRIED __ DIVORCED__ MINOR __

SOC SEC #: _____ DATE OF BIRTH: _____ AGE: _____

EMERGENCY CONTACT PERSON: _____ PHONE: _____

FAMILY MEMBERS IN YOUR HOME:

NAME	AGE/DOB	RELATIONSHIP

INSURANCE INFORMATION

Primary Insurance Company Name: _____

ID Numbers: _____

Policy Holder Name: _____ Relationship to Client: _____

Policy Holder Address: _____

Policy Holder Date of Birth: _____ SS#: _____ Phone: _____

Employer and Work Phone: _____

Secondary Insurance Company Name and ID: _____

LIST ANY HEALTH PROBLEMS FOR WHICH YOU (OR YOUR CHILD) CURRENTLY RECEIVE TREATMENT:

_____

_____

PLEASE LIST CURRENT MEDICATIONS: _____

_____

_____

PRESCRIBER OF MEDICATIONS AND PHONE NUMBERS: _____

_____

_____

PRIMARY CARE DOCTOR NAME, ADDRESS, PHONE NUMBER: _____

_____

ALLERGIES: _____

HAVE YOU (OR YOUR CHILD) HAD PREVIOUS THERAPY? IF SO, WITH WHOM AND WHEN?

_____

PRIOR MEDICATIONS: _____

_____

I understand that I am responsible for full payment for the services rendered. Christine Sperrazza, LCMHC, PLLC will submit claims to my insurance company as a service to me. I also understand that I am responsible for obtaining pre-certification from my insurer, billing fees which I might incur, and any late charges on outstanding balances. I am also responsible for collection fees and/or legal fees incurred in settling any outstanding accounts I might have. My signature below authorizes the release of any medical information necessary to the insurer of record so to pay insurance claims for services rendered.

I authorize payment of benefits by my insurer to Christine Sperrazza, LCMHC, PLLC for services described on the health insurance claim form.

_____ _____

Signature Date

If I choose to pay for services on my own and without insurance, I agree to pay $ _____ per session as discussed with my provider. If I choose not to use my insurance and pay privately for services, I agree to waive any right to reimbursement from my insurance company.

_____ _____

Signature Date

I am aware that Christine Sperrazza, LCMHC, PLLC is not credentialed with my health insurance plan. I will be using and understand the process of using my out-of network benefits, and I agree to pay Christine Sperrazza, LCMHC, PLLC her full fee at the time of services. She in turn will give me a superbill to submit to my insurance plan that includes but is not limited to client demographic information, diagnosis, dates of service, and insurance information. My insurance plan may or may not reimburse the fee in full or part, and I understand this depends upon my benefits through the insurance company (i.e., deductible, etc.). My signature below authorizes the release of any medical information necessary from Christine Sperrazza, LCMHC, PLLC to the insurer of record to assist with claims if necessary. My signature below also indicates my full understanding of my out-of network benefit plan, including the fact that I may or may not be reimbursed by my insurance company.

_____ _____

Signature Date