KW COUNSELING SERVICES, LLC

Client Registration

Name of Client____ Today's Date___________________

Home Address____

City:____ Zip__________________________

Phone number:____________________________________ Land Line Cell Phone Work Phone (circle one)

Date of Birth____________________________ Age__________________

Occupation______________________________ Employer____

Marital Status_________ Name of Spouse_________________________ Spouse Date of Birth____________

First names and ages of your children:____

____

Emergency Contact Name, Phone and Relation:

____

PAYMENT INFORMATION

____I will be personally responsible and privately paying for charges of treatment.

____I will be paying for treatment with my insurance. (Please complete insurance information below)

Primary Insurance Company Name:	Secondary Insurance Company Name (if any)
_____________________________________	_______________________________________
Subscriber Name_______________________	Subscriber Name___________________________
Subscriber's DOB______________________	Subscriber's DOB__________________________
Subscriber #___________________________	Subscriber #_______________________________
Employer Group________________________	Employer Group_____________________________
Co-Payment_____________________________	Co-Payment_________________________________

INSURANCE PAYMENT AUTHORIZATION

I hereby direct my insurer to pay directly to KW Counseling Services, LLC and/or my therapist all benefits due them as a result of claims for my treatment. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be valid as the original.

Signature of Patient____ Date_____________________

INSURANCE RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize KW Counseling Services, LLC and/or my therapist to release information concerning my present condition to insurance carrier for the purpose of processing my claims. A photostatic copy of this authorization will be valid as the original.

Signature of Patient____ Date_______________________