KW COUNSELING SERVICES, LLC
Client Registration
CHILD AND ADOLESCENT

Name of client:____Date:____________________________

Home address:____

City:_________________________________State:__________Zip:___________________________________

Home phone:_______________________________ Cell phone:______________________________________

Social Security Number:______________________________

Date of birth:_______________________ Age:__________ Grade level: ________________________________
_
School:____________________________________ Favorite Activity:__________________________________

Who does the child live with?(Biological parent, foster family, other family member?)________________________

Emergency Contact Name Phone and Relation:____

Referred to this office by:____

Physician: _______________________________ Medications: _______________________________________

Physical Illnesses: ____ Allergies:_________________________
____

PARENT INFORMATION

Guardian's/Mother's Name:_________________________ Social Security #:_____________________________

Address(if different from above):____

City:_________________________________State:____________Zip:_________________________________

Date of birth:_______________________Age:__________Occupation:_________________________________

Home phone:_________________________Work phone:_______________Cell phone:___________________

Employer:_______________________________Emp. Address:______________________________________

Guardian's/Father's Name:___________________________Social Security #:___________________________

Address(If different from above):____

City:________________________________State:___________Zip:___________________________________

Date of birth:_______________________Age:__________Occupation:_________________________________

Home phone:______________________Work phone:___________________Cell phone:__________________

Employer:___________________________________Emp. Address:__________________________________

Other siblings: Name:________________________________Age:______DOB:_____________Sex:________

Name:________________________________Age:______DOB:_____________Sex:________

Name:________________________________Age:______DOB:_____________Sex:________

OVER…please complete other side also!

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:
____
Subscriber Name________________________
Subscriber's DOB________________________
Subscriber #___________________________
Employer Group_________________________
Co-Payment: $__________________________

Secondary Insurance Company Name (if any)
____
Subscriber Name_____________________________
Subscriber's DOB_____________________________
Subscriber #_________________________________
Employer Group______________________________
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**________________________