Wandrei Psychological Services, LLC

REGISTRATION AND CLIENT INFORMATION FORM

(Please Print)

Today's date:					
CLIENT INFORMATION					
Client's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced
Parent/Guardian:					
Student: ❑ Full-Time ❑ Part-Time School Name:					
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security No.:			Home Phone No.: ( )
Email Address:					Cell Phone No.: ( )
P.O. Box:	City:	State:	ZIP Code:		
Occupation:	Employer:				Employer Phone No.: ( )
Chose clinic because/Referred to clinic by (please check one box):	❑Dr.	❑ Insurance Plan			
❑ Family	❑ Friend	❑ Close to home/work	❑ Other		
Other family members seen at here:					

INSURANCE INFORMATION					
(Please give your insurance card to your therapist.)					
Person responsible for bill:	Birth date: / /	Address (if different):			Home Phone No.: ( )
Is this person a client here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:			Employer Phone No.: ( )
Relationship to client:					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. No.:	Birth date: / /	Group No.:	Policy No.:	Co-payment: $
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Client's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
In case of emergency, who should be notified?	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )
If we can't reach the above person, who is the alternate person that should be notified in the case of emergency?	Relationship to client:	Home phone no.: ( )	Work phone no.: ( )

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____

Name of Insurance Company

and assign to Wandrei Psychological Services, LLC ("WPS") all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize WPS to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission whether manual or electronic.

The information set out in this form is true to the best of my knowledge.

Client/Guardian signature *Date*

FINANCIAL RESPONSIBILITY

It is agreed and understood that if this financial obligation owed to WPS for services rendered should become delinquent, I, the client and/or responsible party, agreed to be obligated for collection costs, attorneys' fees, interest and any associated costs of litigation to collect this debt. It is also agreed and understood that if this obligation should become delinquent WPS may charge up to a late fee of 1.5% per month on the principal past due amount and I agree to be response for said late finance charges.

By signing below, I also indicate that I understand that WPS' policy is to bill clients for missed appointed for which a 24-hour notice is not given.

I have received and reviewed this information sheet and agree to be bound by the terms set out herein.

Client/Guardian signature *Date*