A Perfect Peace of Mind Counseling
REGISTRATION FORM

Today's Date: _____

CLIENT INFORMATION

Client's last name: _____ First: _____ Middle: _____

Marital status: [Choose an item]	___Single ___Married ___Divorced ___Widow(er)	Birth date: _____	Age: _____	Sex: ○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security No.: ____ - _____ - _____	Home phone no.: ____ - _____ - _____	Cell phone no.: ____ - _____ - _____
Occupation: _____	Employer: _____	Your Email: _____

CURRENT SYMPTOMS

Check all that apply: ___Depression ___Sleep Disturbance ___Feelings of Worthlessness and Hopelessness ___Suicidal Ideation ___Substance Abuse ___Other

INSURANCE INFORMATION

Person responsible for bill: _____	Birth date: _____	Address (if different): _____	Home phone no.: ____ - _____ - _____
Occupation: _____	Employer: _____	Employer address: _____	

Please indicate primary insurance: [Choose an item] | Other: [Other 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 Other: [Relationship to subscriber]

Name of secondary insurance (if applicable): _____	Subscriber's name: _____	Group no.: _____	Policy no.: _____

Client's relationship to subscriber: [Choose an item] | Other: [Relationship to subscriber]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____	Relationship to client: _____	Home phone no.: ____ - ____ - _____	Cell phone no.: ____ - ____ - _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize APPOMC or insurance company to release any information required to process my claims.

_____ _____

Client/Guardian signature Date