Stepping Stones Counseling Services

Registration Form

(Please Print)

Appointment date and time **Therapist:**

Patient Information

Patients last name:_____ First:_____ Middle:_____

Marital status (circle one) **Single / Married / Divorced / Separated / Widowed**

DOB: _____/_____/_____ **Age:** **Sex: M☐ F☐** **Social Security No: _____-____-_____**

Street Address_____ **Phone #: ( ) ____-_____**

PO Box: **City:** **State:** **Zip Code:**

Parent or Guardian Name: (if minor) **Employer/School Name:**

Choose clinic because/referred to clinic by (please check one) ☐ Dr. ☐ Insurance plan ☐ Hospital

☐ Family ☐ Friend ☐ Yellow Pages ☐ other

Reason for referral:

Insurance Information

(Please give your insurance card to the receptionist)

Is patient covered by insurance? ☐ Yes ☐ No

Name of Primary Insurance: **Phone #**

Subscribers name: **DOB: ____/____/____** **Group #_____** **Policy#_____**

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance:

Subscribers name: **DOB: ____/____/____** **Group #_____** **Policy#_____**

Patients relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

In Case of Emergency

Name of local friend or relative (not living at same address): _____

Relationship to patient:_____ **Home Phone# ( ) _____-_____** **Work # ( ) _____-_____**

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

Patient/Guardian Signature_____ Date:_____