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CLIENT REGISTRATION INFORMATION

PLEASE PRINT

PATIENT INFORMATION (PERSON BEING SEEN)

LAST NAME	FIRST			M.I.
STREET ADDRESS	APT NO.	CITY	STATE	ZIP
SOCIAL SECURITY NO.	DATE OF BIRTH	CELL PHONE NO.	WORK PHONE NO.	
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED ❑ SEPARATED	GENDER	PREFERRED PRONOUN	HOME PHONE NO.	

IS THE PATIENT RESPONSIBLE FOR PAYMENT ❑ YES ❑ NO If No, list responsible parties (e.g., parent or guardian)

NAME **RESPONSIBLE PARTY #1**		NAME **RESPONSIBLE PARTY #2**		
ADDRESS		ADDRESS		
CITY	STATE ZIP	CITY	STATE	ZIP
HOME PHONE NO.	CELL PHONE NO.	HOME PHONE NO.	CELL PHONE NO.	
WORK PHONE NO.	DATE OF BIRTH	WORK PHONE NO.	DATE OF BIRTH	
RESPONSIBLE FOR _____% OF BILL		RESPONSIBLE FOR _____% OF BILL		

FEE INFORMATION: Charges for services are due and payable at the time services are rendered. **THE CLIENT, NOT THE INSURANCE COMPANY,** is responsible for all charges whether or not covered by insurance. If payment is not received within 30 days, your account is considered delinquent and is subject to action by a collection agency, although every effort is made to avoid this. If efforts to arrange payment are unsuccessful and the bill is sent to collection, the balance due will be increased bu the total of all collection agency fees.

CANCELLATIONS: If you need to cancel a session you must provide at least 24 hours advance notice, ot 72 hours notice for a testing appointment. You will be charged for a missed appointment, or an appointment canceled without the appropriate notification (either 24 or 72 hours).

SIGNATURE OF RESPONSIBLE PARTY: _____DATE: _____