Pyramid of Hope Counseling, LLC

Client Registration

Date of first visit_____

Client's Full (Legal) Name _____

Date of Birth_____ Age_____ Phone #_____

Gender_____ Address_____

City_____ State_____ Zipcode_____

Relation Status_____ Email Address_____

Is this client a Minor? **Yes** **No** If Yes, is there a Parental Custody/Visitation Schedule? **Yes** **No**

Contact Person:_____ Relationship to Client_____

Employment

Place of Employment_____

City_____ State_____ Zipcode_____

Work Phone_____ Length of Employment_____

Job Title/Duties_____

Primary Insurance

Policy Holder/Name on Card_____

Policy Holder's Date of Birth_____ Relationship to Client_____

Policy Holder's Employer_____

Type of Insurance_____

Contract/Member ID #_____ Policy Group #_____

Policy Holder's Street Address (if different from client's)_____

Policy Holder's City (if different from client's)_____ State_____ Zipcode_____

Secondary Insurance

Policy Holder/Name on Card_____

Policy Holder's Date of Birth_____ Relationship to Client_____

Policy Holder's Employer_____

Type of Insurance_____

Contract/Member ID #_____ Policy Group #_____

Policy Holder's Street Address (if different from client's)_____

Policy Holder's City (if different from client's)_____ State_____ Zipcode_____

*From this date forward, until otherwise notified, I hereby instruct and direct that the above listed Insurance Company/Companies make out and mail **ALL** checks due to Pyramid of Hope Counseling to the following address:*

Pyramid of Hope Counseling, LLC / 5 West Main Street, Unit #3 Boyne City, MI. 49712/ (231)881-5001

*Also, if my current policy prohibits direct payment to doctor then I hereby also Instruct and direct you to make out the check to **Pyramid of Hope Counseling**. For professional/clinical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY FROM THIS DAY FORWARD UNTIL OTHERWISE NOTIFIED. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.*

_____ _____

Client Signature *Date*

_____ _____

Parent/Guardian Signature *Date*

Counselor fills out: Date of Insurance Consent signed_____ Client's ICD-10 DX:_____