

**Registration Form**  
**Reimann Counseling Clinic, PLLC**

DX Code \_\_\_\_\_

Date \_\_\_\_\_

Therapist \_\_\_\_\_

### *Patient Information*

**Patient Name** (Print) \_\_\_\_\_  
Last Name First Name Initial Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Cell Phone \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex:  Female  Male Age \_\_\_\_\_ Relationship Status:  Single  Married  Widowed  Divorced  Separated  Partnered

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_ May we acknowledge this referral? \_\_\_\_\_

### *Primary Insurance*

**Primary Insurance Company** \_\_\_\_\_ Phone \_\_\_\_\_

Ins Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy / Member ID \_\_\_\_\_ Group/Account # \_\_\_\_\_

**Policy Holder Information:** (if the patient is not the employee/policy holder)

Name \_\_\_\_\_  
Last name First Name Initial Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship \_\_\_\_\_

Soc. Sec# \_\_\_\_\_ Employer \_\_\_\_\_

### *Secondary Insurance*

**Secondary Insurance Company** \_\_\_\_\_ Phone \_\_\_\_\_

Ins Claims Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy / Member ID \_\_\_\_\_ Group/Account # \_\_\_\_\_

**Policy Holder Information:** (if the patient is not the employee/policy holder)

Name \_\_\_\_\_  
Last name First Name Initial Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship \_\_\_\_\_

Soc. Sec# \_\_\_\_\_ Employer \_\_\_\_\_

### *Responsible Party*

(Where should the patient's portion of the bill be sent, if not to the patient?)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### *Assignment and Release*

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance 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 the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_

Date \_\_\_\_\_