MLB Therapy, PLLC

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CLIENT REGISTRATION FORM

Client Information:

Last Name:_____ First Name: _____
Gender: M / F Date of Birth:_____/_____/_____ Social Security Number:_____-_____-_____
Marital Status (circle one): Single Married Divorced Separated Widowed Other_____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer:_____
E-mail: _____

Emergency Contact:

Name: _____
Home Phone: _____ Cell Phone:_____
Work Phone: _____ Relationship: _____

Parent / Guardian Information: Required if client is under 18 years of age.

Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____SSN: _____-_____-_____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Employer:_____

Custody Status:_____
Legal: _____Physical: _____

Referral Source: _____

Financially Responsible Party (If different than client):

Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____SSN: _____-_____-_____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Employer:_____

FEES- FOR- SERIVCE:

Please understand that services are fee-for-service. All fees and balances are due at the start of each visit. An itemized receipt can be provided for you to submit to your respective insurance company if desired. If you would like a receipt for payments made, please request one and it will be provided.

Please note: MLB Therapy, PLLC will only bill to primary insurance policies.

Please ***initial*** each of the following statements:

	I understand that regardless of insurance reimbursement, I am financially responsible for all services and associated fees accumulated, to and including any no show/late cancellation fees and case management fees.
	I agree to pay for all fees at the start of each visit. Should my account become behind, I understand services may be postponed until the account balance is resolved.
	I agree to allow MLB Therapy, PLLC to release any necessary information that I have provided to collect reimbursement from a financial institute/provider that will reimburse/collect payment for services, including, but not limited to Employee Assistance Programs and/or collection agencies.
	I authorize MLB Therapy, PLLC to contact me and leave me messages using any of the provided contact information.

_____ _____

Client / Financially Responsible Party's Signature Date