Registration Form

East Metro Family Counseling, LLC

Mitch Leppicello, LICSW

Date: _____ DX Code: _____ (office only)

Patient Information

Patient Name (Print): _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

Street Address: _____

City: _____ State: _____ Zip: _____

Mobile/Cell: _____ Home or Wk Ph: _____ Emerg Ph: _____

Email: _____

***May we use text messaging and email for appt and other EMFC business communications? Y or N**

Age: _____ Referred By: _____ May we acknowledge this referral? _____

Gender: Female Male Relationship Status: Single Married Separated Divorced Partnered Widowed

Primary Insurance: Primary Insurance Company: _____

Effective date of Ins: _____ 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: _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

Address: _____ City: _____ State: _____ Zip: _____ Relationship: _____

Soc. Sec. #: _____ Employer: _____

Secondary Insurance: Secondary Insurance Company: _____

Effective date of Ins: _____ 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: _____ Date of Birth: _____
(Last Name) (First Name) (Initial)

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 to Patient Date