CWM COUNSELING

DIAGNOSIS: _____

PLACE OF SERVICE: _____

30 MIN 45 MIN 60 MIN

530 S WATER ST. STE 3, PLATTEVILLE, WI 53818 3343
CENTER GROVE DR. STE A, DUBUQUE, IA 52003
(608) 348-5088

INTAKE DATE:_____

THERAPIST: _____

CLIENT ID:_____

CLIENT REGISTRATION FORM

CLIENT INFORMATION

_____
First Middle Last

_____
Street Address

_____
City, State, Zip code

_____
Phone Number Date of Birth

_____ M / F
Cell Phone Number Sex

_____
Patient Email

S _ M _ D _ W _____
Marital Status Name of Spouse

Self-Pay $_____ per session _____ (initial here)

BILLING INFORMATION
(**If Different Than Client Information**)

_____
Responsible Party for Bill

_____
Street Address

_____
City, State, Zip Code

_____
Responsible Party Email Address

_____
Responsible Party's Employer

_____
Responsible Party's Employer Address and Phone

Emergency Contact_____

****PLEASE PROVIDE YOUR THERAPIST WITH ANY AND ALL INSURANCE CARD(S) AT YOUR INITIAL VISIT****

PRIMARY INSURANCE

_____
Policyholder Name **Policyholder Date of Birth**

_____
Insurance Company Name

_____
Insurance Street Address

_____
City, State, Zip Code

_____
Member ID# Group #

Medicaid #: _____

SECONDARY INSURANCE

_____
Policyholder Name Date of Birth

_____
Insurance Company Name

_____
Insurance Street Address

_____
City, State, Zip Code

_____
Member ID# Group #

Medicaid #: _____

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office. I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: CWM Counseling. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Patient Signature_____Date_____