CALIFORNIA COUNSELING ASSOCIATES

NEW CLIENT REGISTRATION FORM

Therapist: _____

CCA.NCRF.0721

Name: _____ Last Name: _____ Initial: _____

Address: _____ Apt/Space #: _____

City: _____ State: _____ Zip: _____ Marital Status: M/S/D/W Select One

DOB: _____ Gender: _____ Social Security Number: _____

Home Phone: _____ Cell: _____ Email: _____

Employer: _____ Address: _____

Primary Doctor: _____ Referred by: _____

Responsible Party

Name: _____ Last Name: _____ Initial: _____

Address: _____ Apt/Space #: _____

City: _____ State: _____ Zip: _____ Marital Status: M/S/D/W Select One

DOB: _____ Gender: _____ Social Security Number: _____

Home Phone: _____ Cell: _____ Email: _____

Employer: _____ Address: _____

Emergency Contact

Full Name / Relationship to patient: _____

Home Phone: _____ Cell: _____ Email: _____

Insurance Information

Primary Insurance: _____

Address: _____

City/State/Zip: _____

Insurance ID#: _____

Group #: _____

Policy Owner Name: _____

DOB: _____ Relationship: _____

Authorization #: _____

Secondary Insurance: _____

Address: _____

City/State/Zip: _____

Insurance ID#: _____

Group #: _____

Policy Owner Name: _____

DOB: _____ Relationship: _____

Authorization #: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS

I hereby authorize California Counseling .Associates to treat the above named patience. I authorize the release of medical information necessary to secure payment from insurance(s) or third parties. I authorize payment of medical benefits to be paid directly to California Counseling Associates. I understand that I am financially responsible to for any amounts not covered by my heath insurance.

Signature: _____ Date: _____

"My typed signature here represents my legal signature, confirming that I have read this document and agree to the terms stated herein."