Canyon Hills Counseling, LLC

*Make Life Beautiful Again*

# REGISTRATION FORM

**(Please Print)**

| Today's date: | Primary Care Physician/Pediatrician: |
|---|---|

## CLIENT INFORMATION

| Last Name: | First: | Middle: | ○ Mr. ○ Miss ○ Mrs. ○ Ms. | Marital status: ○ Sgl. ○ Mar. ○ Div. ○ Sep. ○ Wid. |
|---|---|---|---|---|

| Is this your legal name? ○ Yes ○ No | If not, what is your legal name? | (Former name): | Birth date (mm/dd/yy): | Age: | Sex: ○ M ○ F |
|---|---|---|---|---|---|

| Street address: | Social Security No: | Home phone: |
|---|---|---|

| City: | State: | Zip Code: | Cell phone: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone: |
|---|---|---|

Chose CHC because/Referred by (please check one): ○ Doctor: ○ Insurance Plan ○ Hospital ○ Family ○ Friend ○ Location ○ Website ○ Other (please specify):

Other family members seen here: _____

## INSURANCE INFORMATION

| Person responsible for bill: | Birth date: | Address (if different): | Best contact phone number: ○ Home ○ Cell ○ Work |
|---|---|---|---|

Is this person a client here? ○ Yes ○ No

| Occupation: | Employer name & address: | Employer phone: |
|---|---|---|

Is this client covered by insurance? ○ Yes ○ No

Primary insurance:

| Subscriber's name: | Subscriber's SSN: | Birth date: | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Client's relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

Secondary insurance:

| Subscriber's name: | Subscriber's SSN: | Birth date: | Group no.: | Policy no.: | Co-payment: $ |
|---|---|---|---|---|---|

Client's relationship to subscriber: ○ Self ○ Spouse ○ Child ○ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to client: | Home / Cell phone: | Work phone: |
|---|---|---|---|

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Canyon Hills Counseling, LLC. I understand that I am financially responsible for any remaining balance. I also authorize Canyon Hills Counseling, LLC, to release any information required to process my claims.

| Client/Guardian signature: | Printed name: | Date: |
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