



Calming Journeys Counseling, S.C.

Patient Registration Form

(for Office Use Only)

New _____ Change _____ Date: _____

Therapist: _____ Physician: _____ Dx: _____

First _____ Middle _____ Last _____

Responsible Party **Billing Information if Other Than the Patient**

Birthdate: _____ Gender: _____

First _____ Middle _____ Last _____

Street Address _____

Street Address _____

City, State, Zip code _____

City, State, Zip code _____

Phone Number _____

Email _____

Cell Phone _____

Employer _____

Email _____

Employer Address _____

Please check preferred method for appointment reminders:

Employer Phone _____

Text Email Phone/Voicemail

Please check: Single Married Divorced Widowed

Spouse / Partner Name _____

Employer _____ Employer Address _____ Employer Phone _____

Calming Journey Counseling, S.C. will bill the insurance company as a courtesy to the client. The client is ultimately responsible for the payment of all services.

Fee: Your fee will be _____ per 50 to 60 minute session.

Insurance Company Name _____

Secondary Insurance _____

Ins Policy Holder _____ Date of Birth _____

Ins Policy Holder _____ Date of Birth _____

Ins Street Address _____

Ins Street Address _____

City, State, Zip code _____

City, State, Zip code _____

Insurance ID Number _____ Group # _____

Insurance ID Number _____ Group # _____

Authorization / Assignment of Benefits: Please sign by the 'X' for release of your records to your insurance for medical information necessary to process insurance and for payment to Calming Journeys Counseling, S.C. by your insurance. This authorization will remain in effect until revoked by the client in writing. A photocopy of this authorization is to be considered as valid as the original copy.

I understand that partial payments by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I agree to the stated fees and I understand that I am responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee, Calming Journeys Counseling, S.C. to release all information to secure payment on my behalf.

X _____ Date _____