Aspects of Life
COUNSELING SERVICES

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Patient Registration

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone:_____ Cell/Other Phone:_____

Student Status: ☐ Full-time ☐ Part-time ☐ Not a student School: _____ Grade: _____

Ethnicity: _____ Preferred Language: _____ Race: _____

Guarantor: _____ Phone: _____

Employer: _____ Relationship to Patient: _____

Primary Insurance Information

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

Policy #: _____ Group #: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Information ☐ **Check here if you have no secondary insurance**

Insurance Company: _____ Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

Policy #: _____ Group #: _____

Relationship to Patient: _____ Employer: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Shannon Hayes, PsyD 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 authorize the use of my signature on all insurance submissions. I/We hereby state that the information above is true and correct to the best of my/our knowledge.The above name provider may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the above signed date.

_____ _____

PRINT NAME OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT | RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE OF PATIENT, PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT | DATE