Date_____

REGISTRATION FORM

Name of Client: _____

Spouse/Partner's Name:_____

Parents' Name (If under 18 y.o.):_____

Address: _____
Street City/State Zip Code

Phone: HOME ( )_____ WORK ( )_____

Cell ( )_____Email_____

Date of Birth: _____Age: ___Marital Status: _____SS#_____

Place of Employment: _____

Primary Care Physician (PCP): _____Phone #:_____

Responsible Party (Statements will be sent to):

Name: _____Relationship to Patient:_____

Address: _____Phone #: _____

Insurance Information:

Insurance Carrier: _____Phone #: _____

Name of Employee: _____ID #: _____

Employer: _____Group #: _____

Person to contact in case of emergency:

Name: _____Relationship:_____ Phone#_____

Who referred you? _____

I hereby authorize the therapist to release all information about me required to get authorization for therapy sessions and to process insurance claims. I further authorize payment directly to Janet E. Esposito, LCSW of benefits due me for services rendered and agree to sign over insurance checks or issue payment due if I am reimbursed directly by the insurance company. I understand I am financially responsible for charges not covered by insurance, including any applicable deductibles or co-payments. I further understand I am responsible for fees for broken appointments or cancellations without 24 hours notice.

CLIENT'S OR AUTHORIZED PERSONS' SIGNATURE **Date**

**********OFFICE USE ONLY**********

Referred by _____Therapist_____

Axis I

DX: _____ _____ Office: Danbury _____

8.99