Sheila Hedden, L.C.S.W.

Client Registration Form

Client's Name _____ E-mail Address _____

Address _____City: _____State _____ Zip _____

Age _____ Date of Birth _____ Marital Status _____ Work Phone _____

Home Phone _____ Cell Phone _____

Name of Spouse/Parent _____ Cell Phone _____

Age _____ Date of Birth _____ Employer _____

Emergency Contact _____ Phone _____

Referred by _____

Insurance Information

Primary Insurance _____ I.D.# _____ Group# _____

Policy Holder _____ Relationship to Client: ( ) Self ( ) Spouse ( ) Parent

Policy Holder's address _____

Policy Holder's Employer _____ D.O.B. _____

Type: ( ) P.P.O ( ) HMO ( ) Other _____ Effective Date _____

Has deductible been met? Yes / No Annual deductible amount: $ _____ Co-payment: $_____

Do you have a secondary insurance carrier? Yes / No If yes, name of insurance _____

I certify that the information given is correct. I give Sheila Hedden, LCSW permission to administer a psychosocial assessment and treatment deemed therapeutic to my condition. I also authorize the release of any medical or other information necessary to process insurance claims. I certify that I have read and understood the office policies and accept total financial responsibility for all services rendered.

_____ _____

Signature of Client/Guardian Date

Notice of Privacy Practices, Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. My Notice of Privacy Practices provides information about how we may use and disclose your medical information. I encourage you to read it in full.

_____ _____

Signature of Client/Guardian Date