

**Client Registration**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ SS# \_\_\_\_\_  
Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Student \_\_\_  
Employer \_\_\_\_\_ Full-time \_\_\_ Part-time \_\_\_ Retired \_\_\_ Self \_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ Email \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ SS# \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Person Responsible for Payment**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Client \_\_\_\_\_ Driver's Lic/State \_\_\_\_\_  
Employer \_\_\_\_\_ Full-time \_\_\_ Part-time \_\_\_ Retired \_\_\_ Self \_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_ Email \_\_\_\_\_

**Primary Insurance Company**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_ Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_  
Birthdate \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Employer/Group Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ SS# \_\_\_\_\_

**Secondary Insurance Company**

Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Policyholder's Name \_\_\_\_\_ Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_  
Birthdate \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Employer/Group Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ SS# \_\_\_\_\_

**Authorization to Release Information and Assign Benefits**

I authorize the release of any medical or other information to the above named insurance company(s) and/or their designated agent(s) necessary to approve and/or pay this claim. I hereby assign and authorize payment of all medical benefits payable pursuant to this claim to Southside Counseling Center, LLC, for services rendered; I also agree to pay any applicable co-payments and outstanding account balances. **If my therapist accompanies me to or testifies on my behalf in any court proceeding, I agree to pay said therapist the hourly fee of \$250 for all time spent, including preparatory and travel time. I understand that SCC has the right to charge, and I agree to pay, 50% of my negotiated hourly fee for no-shows and late cancellations.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_