Please complete at your earliest convenience and:
___Return in enclosed envelope
___Bring to next session

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Adult Client Registration Form

Today's Date: _____ Referred by: _____
Name: _____ DOB: _____ SSN: _____
Mailing Address: _____City: _____ Zip: _____
Billing Address: _____City:_____Zip:_____
Home Phone: _____ Mobile/Message Phone: _____
May we call you at home? Yes No Okay to leave message at home? Yes No
Ethnicity: _____ Pronouns:_____ Gender Identity:_____

Occupation: _____ Employer: _____
Work Address: _____ City: _____ Zip: _____
Work Phone: _____ May we call you at work? Yes No Okay to leave message? Yes No

Circle Current Status: Single Married Separated Widowed Divorced
Spouse/Partner Name (if appropriate): _____
How long in Relationship? _____
Names & Ages of Children:_____
_____

Emergency Information
Emergency Contact Name: _____ Rel. to Client: _____
Contact Home Phone: _____ Contact Work Phone: _____

Primary Care Physician: _____
Physician Phone: _____ Fax: _____
Physician Address: _____City: _____ Zip: _____

Insurance & Health Care Information (Please submit your insurance card at first session so we can Xerox a copy)
Primary Insurance Company: _____ Phone: _____
Insured's Name: _____ Insured's DOB: _____
Relationship to Client: _____ Insured's SSN: _____
Group/Employer Name: _____ ID #:_____
Group #: _____ Authorization/Claim # (if applicable): _____

Secondary Insurance Co. Name: _____ Phone: _____
Insured's Name: _____ Insured's DOB: _____
Relationship to Client: _____ Insured's SSN: _____
Group/Employer Name: _____ ID #:_____
Group #: _____ Authorization/Claim # (if applicable): _____

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necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, we will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client Signature (Parent/Guardian if Minor) Date

_____
Printed Name

_____ _____
Co-Signature (if required) Date

_____
Printed Name of Co-Signer

Please sign and return with your Intake form. You should have received a complete copy of this form, If not, or if you have any questions, please contact Dr. Provenzano.

Original 4/14/03; Revised 3/21