

The Ardent Counseling Center REGISTRATION FORM

Instructions: Please fill out this form and also make a copy of your insurance card and attach it.
(Please make multiple copies of this form for each family member being seen)
Please fax back to (847) 349-1619, or email attachment to sonya@ardentcenter.com

OFFICE USE ONLY

Today's date:	Co-payment: \$
Office Location:	Clinician Assigned:

CLIENT INFORMATION

Client's last name:	First:	Middle:
Marital status.: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No
If not, what is your legal name?		(Former name):
Age:	Date of Birth: / /	
Street address:	P.O. Box:	
City:	State:	ZIP Code:
Social Security no.: - -	Best Contact number: () -	
Occupation:	Employer:	
Employer phone no.:		

MISCELLANEOUS INFORMATION

Referred to The Ardent Center by (please check one box):	<input type="checkbox"/> Dr.
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital referral <input type="checkbox"/> Search Engine <input type="checkbox"/> Website	
If you used a search engine :	<input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Lycos <input type="checkbox"/> MSN Key Words Used:

INSURANCE INFORMATION

(Please give your insurance card to the therapist.)

Person responsible for bill:	Birth date: / /
Address (if different):	
Home phone no.:	Is this person a Client here? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer:	Occupation:
Employer address:	Employer phone no.: () -
Is this Client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Subscriber's name:
Subscriber's S.S. no.: - -	Birth date: / /
Group no.:	ID number:
Insurance Company Name:	
Insurance Billing Address:	Insurance phone no.: () -
Client's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's name:
Group no.:	ID number:
Insurance Billing Address:	Insurance phone no.: () -
Client's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative:

Relationship to Client:

Home phone no.: () -

Work phone no.: () -

I give permission to The Ardent Counseling Center and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles, and non-covered services I will be responsible for. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at \$75.00. I understand that my insurance nor EAP does not cover the cost of missed sessions. I understand that therapist may not be able to schedule a session until all unpaid balances such as due copays are collected.

Client/Guardian signature

Date.: