BURKE + UNGER
LifeWorks
COUNSELING LLC

CLIENT REGISTRATION
(PLEASE PRINT)

Date: _____

Client Name:_____

Parent/Guardian/Personal Representative: _____

Relationship Status: Single Married Partner Separated Divorced Widowed

Date of Birth: _____Age: _____ Sex: M or F Social Security #: _____

Home Address: _____

Home Phone: _____ Cell:_____ Work: _____

Email Contact:_____

Emergency Contact/Relationship: _____ Phone #: _____

Client's Employer: _____ Phone #:_____

Student: School Name:_____ Grade Level:_____

Parent's Marital Status: Single Married Divorced Separated Widowed

Parent's Date of Birth: Mother _____ Father_____

Primary Care Physician (PCP): Name: _____ Phone #:_____

Address: _____

*To provide excellent care, we request to contact your PCP: Yes ___ No ___ Initial_____

Psychiatrist Name: _____ Phone #: _____

Address: _____

*To provide excellent care, we request to contact your Psychiatrist: Yes ___ No ___ Initial_____

List all Medications - including over the counter: _____

_____

Allergies: _____

Past Treatment Outcome: What worked? What did not? _____

_____

What goals do you want to accomplish during treatment?_____

_____

_____

Why are you seeking treatment at this time? _____

_____

List current symptoms:_____

_____

_____

INSURANCE/RESPONSIBLE PARTY INFORMATION

Full name of Insured: _____
Relationship: _____ Occupation: _____ Phone #: _____
Home Address: _____
Employer Address: _____Employer Phone #: _____
Insured's SS#: _____ Driver's License #: _____ State:_____
Name of Spouse: _____ SS#: _____ Occupation: _____
Spouse's Employer: _____ Phone #: _____
Primary Insurance Co: _____ ID#: _____ Group#: _____
Mental Health Claims Address: _____
Phone #: _____ Insurance Co-Pay Amount:_____
Secondary Insurance Co: _____ ID#: _____ Group#: _____
Job Related Injury-Workman's Comp: No / Yes Company: _____
***It is your responsibility to call your insurance company to check on your member benefit and get authorization for payment of treatment.**
Did you get authorization? Yes or No Authorization #: _____
Referral Source: _____

****It is your responsibility to pay any co-pay, co-insurance, deductible amount or any other balance not paid by your insurance company on the day and time service is provided.**
I authorize/understand/release the following:

1. **I authorize the use of this form for all my insurance submissions.**
2. **I authorize the release of information to my insurance company(s).**
3. **I authorize direct payment to Burke and Unger LifeWorks Counseling LLC as my service provider.**
4. **I understand that I am responsible for the full amount of my bill for services provided before the start of each session.**
5. **I authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable.**
6. **I hereby permit a copy of this form to be used in place of an original.**

Cancelled/Missed Appointments
A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four hours (24) notice, you will be billed a $50 cancellation fee. *Your health plan does not cover payment for missed appointments; therefore, you are responsible for payment of your fee in full.

I understand and agree to all of the above information.

Client (or Parent/Guardian) Name Date