CLIENT REGISTRATION

Barbara E. Doak, LCSW, LLC

460 Squaw Hollow Road, Ashford, CT 06278

TODAY'S DATE _____ ***Email: bd7553@gmail.com*** **860-942-6316**

Client Name:_____Gender: M_____ F _____

Address:_____ City:_____State:_____ Zip:_____

Date of Birth: _____ Email:_____

Home Telephone # _____ SS# _____ Cell # _____

Text messaging ___Yes ___ No

INSURANCE INFORMATION **Primary Insurance Company**:_____

ID#_____Group #_____ Relationship to Client:

Self___ Spouse____ Parent_____

Policy Holder/Employee's Name:_____

Address if different from client:_____

Employee's Birth Date:_____

Employed by:_____ Gender: Male_____ Female_____

Secondary Insurance Company:_____ ID#_____

Policy Holder/Employee's Name:_____ Relationship to Client: Self___Spouse____Child____

Employed by:_____ Employee's Date of Birth:_____

Primary Care Physician:_____**Phone:**_____

List of Medications:_____

_____

_____

Client Signature:_____ **Date:**_____

Guardian/Parent (if minor) _____ **Date**:_____

*Co-payments and Deductibles are due at the time services are rendered. Notice of cancellation is required 24 hours prior to your scheduled appointment to avoid a $75 missed appointment fee.

******** *OFFICE USE ONLY* ********

Co-Payment Due: _____ Primary DX Code:_____ Secondary DX Code:_____

Deductible Due: _____ Prior Auth/ #Sessions approved:_____ Effective Dates: _____ to _____