WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 330
Burlington VT 05401

REGISTRATION FORM

Client Name: _____ Date of Birth: _____/_____/_____ M/F

Address: _____ Social Security Number: _____-_____-_____

(Street)

Address: _____ Email Address_____

(City/State/Zip)

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Work Phone: (_____)_____-_____ Can we leave a message at any of these numbers? H C W (circle)

Primary Care Physician: _____ Phone number: (_____)_____-_____

Name of Guardian/Parent (if applicable): _____

Emergency contact: _____ Phone: (___) _____ - _____

How did you hear about our practice? _____

FIRST INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Co-pay amount $_____ HSA? yes/no (circle one) High-deductible? yes/no (circle one)

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Policy Holder: _____ Co-pay amount $_____ Group Number: _____

Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

PERSON RESPONSIBLE FOR BILL

Guarantor Name: _____ Date of Birth: _____/_____/_____

Relationship to Client: (check one): ( ) self, ( ) spouse, or ( ) parent/guardian Phone Number: (___) _____

Address (if different from client): _____

(Street) (City/State/Zip)

Signature: _____

PERSON(S) WHO HAVE LEGAL CUSTODY

Name(s)_____

Signature: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Water's Edge Psychotherapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____/_____/_____

Therapist_____ DX:_____ 1st Date of Service: _____/_____/_____