Client Registration Form

First Name: | Last Name: | M.I.:

Address:

City: | State: | ZIP:

Home Phone: | Work Phone:

Birth Date: / / | Age: | Social Security #: - - | Sex: M F

Employer's Name: | General Practitioner's Name:

Current Medications: | Cell Phone:

If the client is a minor, please fill in the parent's name and work telephone numbers below.

Parent Name: | Parent Name:

Parent Work Phone: | Parent Work Phone:

Primary Insurance Company

Ins. Co. Name: _____

Ins. Address: _____

_____

Ins. Phone #: _____

Group #: _____

ID#: _____

Subscriber's Name: _____

Subscriber's DOB:

Secondary Insurance Company

Ins. Co. Name: _____

Ins. Address: _____

_____

Ins. Phone #: _____

Group #: _____

ID#: _____

Subscriber's Name: _____

Subscriber's DOB:

Who referred you to my office:

☐ Doctor ☐ Therapist ☐ Other

Name:

I authorize Sonny Provetto, LICSW, to send a summary of my initial evaluation to my referring doctor or therapist. ☐

Signed: Date: / /

If the person responsible for the bill is not the client, please fill in this section:

Person responsible for bill: | Their phone #:

Their address:

City: | State: | ZIP:

MISSED AND CANCELED APPOINTMENTS: There will be a charge for appointments that are missed or canceled with less than 24 hours prior notice. **Cancelation charge $45**

Client's Signature: Date: / /

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Sonny Provetto, LICSW, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.

Client's Signature: Date: / /