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ADULT REGISTRATION FORM

Name_____ Birthdate____/_____/_____

Address_____ SSN_____-_____-_____

City/State/Zip_____ Marital Status_____

Occupation/Education_____ Referred By_____

Reason for appointment_____

Home Phone_____-_____-_____ May I Leave a Message? Y N

Cell Phone _____-_____-_____ May I Leave a Message? Y N

Work Phone_____-_____-_____ May I Leave a Message? Y N

Email:_____ May I Email? Y N

Insurance Policy Holder's Information (if different from client): Birthdate_____/_____/_____

Name_____ SSN_____-_____-_____

MEDICARE CLIENTS: PRIMARY PHYSICIAN'S NAME_____

ADDRESS OR PHONE NUMBER_____

Although many health insurance carriers provide coverage for outpatient mental health services, insurance benefits vary greatly and do not always pay for all charges. You are responsible for payment of all fees for services rendered.

Cancellation or Failure to Keep Appointments: Please be aware that you will be charged the usual session fee for any appointment missed unless you provide notification 24 hours before the appointment by leaving a message at 708-620-2829. Insurance does not pay for missed appointments.

Agreement to Terms of Service

- I understand that a diagnosis will be submitted to my insurance company if I choose to file a claim and reports about my treatment and progress toward goals may be required by the company.
- If the person who referred me was a professional (psychologist, medical professional, attorney), that person may be contacted for information and to confirm that I have come for services.
- I have received a copy of the Outpatient Service Contract.
- I have read the information above and agree to the terms of service.

Signature_____ Date_____

For Office use only:
Carolyn Nowakowski, Psy.D. _____Date_____Dx Code_____