



REGISTRATION INFORMATION
(PLEASE PRINT)

Date _____ Home Phone _____
Client _____ Cell Phone _____
Last Name First Name Initial
Responsible Party (if minor) _____
Street Address _____ Email _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor Separated Divorced
 Partnered for _____ years
Client Employer/School _____ Occupation _____
Spouse (or responsible party) Employed by _____ Occupation _____
Purpose of visit _____
Who is responsible for this account? _____ Relationship to client _____
Social Security # _____ Spouse's Social Security # _____

Do you have insurance? Yes No If yes,
Name of Primary Insurer _____
Contract # _____ Group # _____ Subscriber # _____
Name of Secondary Insurer (if any) _____
Contract # _____ Group # _____ Subscriber # _____
 Medicare Medicaid Claim # _____
If Welfare, your number _____ County of _____
In case of emergency, who should be notified? _____ Phone _____
How did you learn of our practice? _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to **Sophia Center, Inc.** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

The above named Sophia Center may use my information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ By marking this box you have agreed to allowing us to bill your insurance and will take responsibility for all amounts that your insurance company has deemed patient/subscriber responsibility.

Signature of Client or Personal Representative _____ Date _____

Please print name of Client, Parent, Guardian or Personal Representative _____ Relationship to Client _____