Balanced Life Counseling LLC.

950 West Monroe., Ste. G100 Jackson MI 49202

Registration Form

Patient's Name: _____ Date: _____

S.S. #: (last 4 digits)_____ D.O.B. _____ Home #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work #: _____

Are issues work related? [ ] Yes [ ] No Sex: [ ] Female [ ] Male

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Responsible Party: _____ S.S. #: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance _____ Phone #: _____

Policy #: _____ Policy Holder: _____

Secondary Insurance: _____ Phone #: _____

Policy #: _____ Policy Holder: _____

EMERGENCY CONTACT (that we may call or leave a message with regards to your appointment)

Name: _____ Relationship: _____

Work #: _____ Home #: _____ Other #: _____

INSURANCE REASSIGNMENT OF BENEFITS

I hereby authorize the release of all pertinent information to Balance Life Counseling's biller in order to file for benefits electronically on my behalf for outpatient mental health therapy. Insurance payments should be made payable to Balanced Life Counseling. If I have ***Insurance* coverage**: Balanced Life Counseling is hereby authorized to release information to the insurance carriers for the processing and payment of your claim(s). I certify that I am financially responsible for all services not paid by the insurance company(ies). This authorization is valid indefinitely until revoked in writing by myself or by Balanced Life Counseling.

Signature: _____ Date: _____

Witness: _____ Date: _____