§ Angie Sattler, MA, LPC, CTS § Antione Trent, LMSW, CAAC § Candy Straubel-Sower, LMSW, CAADC § Chris Doucette, LMSW § Dana Beech, LMSW § Derek Robertson, LMSW § Mary McGuire, MA, LMFT, LBSW § § Megan Ledin, LMSW § Perla Garza, LLMSW § § § Sarah Tarkowski, LMSW §

*441 Swartz Court, Ionia, MI 48846 § Phone: 616-523-6537 § Fax: 616-523-6536*

*www.viewpointecounseling.org*

## Registration for Counseling Services

Intake Date_____ Referred By_____

Client's Full Name_____ Date of Birth_____ Age_____

Home Address_____ City_____ State_____ Zip_____

Sex: Male Female Marital Status: Single Married Divorced SSN _____

Home Phone/Cell _____Work Phone _____

**Financial Responsibilities:**

Responsible Party _____ Date of Birth _____

Address (if different) _____ SSN: _____

City _____ State _____ Zip _____

Insurance #1: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Phone #: _____

Insured DOB: _____ Employer: _____

Insurance #2: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Phone #: _____

Insured DOB: _____ Employer: _____

**Emergency Contact:**

Name: _____ Relationship: _____

Phone #: _____ Work #: _____

Primary Care Dr.: _____ Phone #: _____

**Insurance Information (Please Present Insurance Card for Photocopy)**

In order to submit a claim for payment to insurance for services covered under your policy, we must have authorization to release medical information to your insurance company and to our billing company for paper and electronic billing. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize the above provider and their billing company to file for benefits on my behalf for mental health services received. Insurance payments shall be made directly to the provider. If I have Medicare insurance, I authorize the provider to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this of a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the provider by written request. I consent to the provider professional services to me.

Signature: _____ Date: _____