

Client Registration Form

CLIENT INFORMATION					
Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	
Street Address		City		State	Zip Code
School	Grade	Employer		Work Phone ( )	
Referred by		Primary Physician		Home Phone ( )	
Reason for Appointment				Cell Phone ( )	
E-Mail Address					
Emergency Contact Name and Relationship					
Emergency Contact Address			Emergency Contact Phone		
Guardianship Information (if applicable)					
INSURANCE INFORMATION			(Please provide your insurance card to be copied)		
Insurance Provider					
Member's Name		Birth Date	Employer	Group number	
Policy Number			Client's Relationship to Member		
Person Responsible for Bill and Address, if different from above					
Your Signature					
<p>Acknowledges: · Accuracy of above information and <u>financial responsibility</u> to pay any balance and fees for attorney if required for account collection</p> <p>· Receipt and agreement to abide within Dr. Parker's <u>Outpatient Service Contract</u> (revised 1-1-04)</p> <p>· Receipt of <u>HIPAA and State of Alabama policy and practices</u> to protect your health information</p> <p>Authorizes:</p> <p>· Consent for me or my minor child to be evaluated and/or treated by Dr. Kinta Parker</p> <p>· Dr. Parker to <u>release information required to process my insurance claim</u> and for insurance benefits to be paid to Dr. Parker</p>					
_____ Printed Name of Client/Guardian			_____ Date		
_____ Signature of Client/Guardian			_____ Relationship to Client (if not client)		
_____ Witness			_____ Date		