

New Client Registration

Welcome! Please complete this form in its entirety and sign where indicated. The HIPPA brochure and office policy statement are yours to take with you. I look forward to working with you.

Name: _____ D.O.B. ____ / ____ / ____ Age: ____ Sex: ____

Address: _____ City: _____ Zip Code: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

E-mail address: _____

If insurance will be filed, please provide insurance card and picture ID for photocopy.

Insured: _____ Date of Birth: ____ / ____ / ____

Insured's SS # ____ - ____ - ____ Employer: _____

Insurance company: _____ Ins. Co. Phone: _____

Member ID #: _____ Group/Policy #: _____

Primary Care M.D.: _____ PCP Phone: _____

Assignment of Benefits: "I authorize the release of any information necessary to process insurance claims or to certify a need for services. I authorize payment of benefits to Gary Gabbard, LPC for the services provided. If applicable, I also request payment of any government benefits to Gary Gabbard, LPC."

(Signed) _____ (Date) _____

Acknowledgment of HIPPA: "I acknowledge that I have received a brochure explaining Privacy Practices (HIPPA) and that I have been offered the opportunity to discuss these items."

(Signed) _____ (Date) _____

Acknowledgment of policies: "I acknowledge that I have received a copy of the office policies and practices of Gary Gabbard, LPC. and that I have been given the opportunity to discuss these issues."

(Signed) _____ (Date) _____

(Guardian) _____ (Date) _____

Credit card authorization: "I authorize Gary Gabbard, LPC to charge my MasterCard/ Visa card (please circle which one) for payment of services, co-pays and/or 24 hour cancellation policy violation fees unless otherwise paid for by me at the time of service."

Credit Card #: _____ Expiration date: _____

Name on the card: _____ Zip code billed to: _____

(Signed) _____ (Date) _____

