Client Registration Form
HARMONY PSYCHOTHERAPY CENTER

Patient's Name: _____
Last First MI

Address: _____

_____ Employer: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Sex: _____ DOB: _____ SSN: _____ Marital Status (S/M/D/W): _____

Responsible Billing Name: _____
Last First MI

Address: _____

_____ Home Phone: _____ Work Phone: _____
City State Zip

Primary Insurance Information

Insured's Name: _____
Last First MI

Relationship to Patient: _____ Insured's DOB: _____

Insured's SSN: _____ Insured's Home Phone: _____ Insured's Work Phone: _____

Name of Primary Insurance Carrier: _____

Address: _____

_____ Phone: _____
City State Zip

Policy ID Number: _____ Group Number: _____

Employer: _____

I certify that the information I have provided with regard to my insurance coverage is correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or the above name carrier at anytime in writing. I authorize payment of medical benefits to the provider named for professional services and I authorize only the release of information necessary to process this claim.

Signed: _____

Date: _____

Financial Agreement
HARMONY PSYCHOTHERAPY CENTER

Patient's Name: _____
Last First MI

Responsible Party: _____
Last First MI

Fees and Cancellation Policy

With the exception of emergencies, a minimum of 24 hours notice is required for cancellation of appointments to avoid being billed a fee. Insurance companies will not reimburse for missed appointments.

Payment Agreement

- I authorize Wendy Radding, LCSW, to release information to my insurance carrier.
- I acknowledge responsibility for this account and guarantee payment of all changes against this account.
- I understand that I will be charged a $25 fee for a returned check. I understand that, after a check is returned, I will need to make payments in the form of **cash or a money order**.
- I understand that an account is considered delinquent if the client has not paid the balance within 30 days following written notice of the balance due. Any portion of the account balance over 90 days old may be submitted to a collection agency and subject to a monthly finance charge of 1.5%.
- It will be my responsibility to pay any collection costs, if any.
- I understand that for each 45-50 minute counseling session, I am responsible for the payment of:

_____

The undersigned has read, understands and agrees to all the terms and conditions of this financial agreement:

Signature of Responsible Party: _____

Date: _____