Registration Form
Trellis Counseling, LLC

DX Code _____

Date _____

Patient Information

Patient Name(Print)_____ Date of Birth _____
Last Name First Name Initial
Street Address_____ Primary Phone _____

City_____State_____ZIP_____ Alternate Phone _____
Email: _____ [ ] OK to leave messages at above numbers

Sex: [ ]Female [ ]Male Age_____ Relationship Status: [ ]Single [ ]Married [ ]Widowed [ ]Divorced [ ]Separated [ ]Partnered
Employer_____Occupation_____
Referred by_____May we acknowledge this referral?_____
Emergency Contact _____ Emergency Phone _____

Primary Insurance

Primary Insurance Company_____ Phone _____
Ins Claims Address_____City_____State_____Zip_____
Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)
Name_____ Date of Birth _____
Last name First Name Initial
Address_____City_____State_____Zip_____Relationship_____
Employer_____

Secondary Insurance

Secondary Insurance Company_____ Phone _____
Ins Claims Address_____City_____State_____Zip_____
Policy / Member ID _____ Group/Account #_____

Policy Holder Information: (if the patient is not the employee/policy holder)
Name_____ Date of Birth _____
Last name First Name Initial
Address_____City_____State_____Zip_____Relationship_____
Employer_____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____
Address_____ Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date