JOE BERGER
LICSW

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2 Church Street, Suite 4A, Burlington, VT 05401

CLIENT REGISTRATION FORM

Patient Information

First Name: _____ Last Name: _____ M.I.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: M ☐ F ☐

Employer's Name: _____

General Practitioner's Name: _____

If the client is a minor, please fill in the parent's name and work telephone numbers below.

Parent Name: _____ Parent Name: _____

Parent Work Phone: _____ Parent Work Phone: _____

Insurance Information

Primary Insurance Company:

Ins. Co. Name: _____

Ins. Address: _____

_____

Ins. Phone #: _____

Group #: _____

ID #: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Secondary Insurance Company:

Ins. Co. Name: _____

Ins. Address: _____

_____

Ins. Phone #: _____

Group #: _____

ID #: _____

Subscriber's Name: _____

Subscriber's DOB: _____

If the person responsible for the bill is not the client, please fill in this section:

Person Responsible: _____ Their Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Missed and Cancelled Appointments

There will be a charge for appointments that are missed or canceled with less than 24 hours prior notice.

Client Signature: _____ Date: _____

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to Joe Berger, LICSW for services provided, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of information needed to verify the medical necessity for my evaluation and treatment to my insurance.

Client Signature: _____ Date: _____