Counseling Services
Earnest Ford, MC, LPC
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NEW CLIENT REGISTRATION FORM

(**Please Print Legibly)**

Today's date: x						
CLIENT INFORMATION						
last name: x	**First:**X x	**Middle Initial**	Mr. ❑ Mrs.	❑ Miss ❑ Ms.	XMarital status (circle one) Single / Mar / Div / Sep / Wid	
Address: x	**City**X	State & ZIP CODE x	Birth date: x / /	Age: x	Sex: x❑ M ❑ F	
Email address: **x**			xHome phone #: ( ) xCelluar phone #:			
P.O. box:	City:	State:	ZIP Code:			
Occupation: X	Employer: X					

If you are using your EAP and have certified free sessions, please use the certification number your were provided by your EAP (IBH, EAP Preferred, OPTUM, LIFEWORKS, RESOURCES FOR LIVING, ANTHEM EAP, VITAL WORKLIFE, & OTHER EAPS)

INSURANCE INFORMATION					
X ******PRIMARY INSURANCE CARD HOLDERS'S NAME & DATE OF BIRTH:***					
Insurance Company:	Insurance ID:	Insurance Group #			
xDoes your insurance require prior authorization Does your insurance have a co-pay ? YES NO AMOUNT:____	❑ Yes ❑ No				
First authorization /certification Number: MY2025-8566559					
No. of pre-approved sessions =					
Patient's relationship to subscriber: x	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY (THE PERSON LISTED BELOW IS ALSO SOMEONE YOU CAN TALK TO IN TIMES OF DISTRESS)			
Name of local friend or relative x	Relationship to patient: X	Home phone no.: X	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Counseling Services or insurance company to release any information required to process my claims.

Print Name: _X_____

Signature:_X_____ **Date x**

Patient/Guardian signature *Date*

PATIENT I.D. # (to be completed by provider)_____