Laura Holdcraft, Ph.D., LLC
clinical psychologist

6400 Thornberry Court, Suite 620
Mason, OH 45040

Client Registration Form

Client Name (First MI Last):	Today's Date:	Referred by:
Parent/Guardian Name(s):		
Street Address:	City, State, Zip:	
Primary Contact phone: *Indicate: Cell/home/other* *Client/Spouse/Mother/Father*	Secondary Contact phone: *Indicate: Cell/home/other* *Client/Spouse/Mother/Father*	
Other Contact phone: *Indicate: Cell/home/other* *Client/Spouse/Mother/Father*	Emergency Contact:	
Email address:	Add'l email:	
Best method to send reminders: email text (at cell listed above) Both		
Date of Birth:	Age:	Gender: Male Female
Ethnicity:	Employer or School:	
Marital Status (of parents if child): Indicate: Single, Married, Divorced, Widowed	Occupation (of parents if child):	

If self-paying, only complete name of insurance company:

Primary Insurance Company:	ID #:	Group #:
Insurance phone:	Effective date:	
Insurance Claims Address:	City, State, Zip:	
Subscriber Name:	Subscriber Date of Birth: / /	Subscriber phone:
Subscriber address (if different than above):		
Relation to insured:		
Deductible amount per year:	Copay:	Co-insurance:
For office use:		
Auth Req?	# visits per year:	Payer ID:
Codes Authorized: 90791 90834 90837 90847 90846 96101		

If you have secondary insurance coverage, please provide that information as well.

Secondary Insurance Company:	ID #:	Group #:
Insurance phone:	Effective date:	
Insurance Claims Address:	City, State, Zip:	

PLEASE TURN OVER AND COMPLETE BACK OF PAGE

Subscriber Name:	Subscriber Date of Birth: / /	Subscriber phone:
Subscriber address (if different than above):		
Relation to insured:		
Deductible amount per year:	Copay:	Co-insurance:
For office use:		
Auth Req?	# visits per year:	Payer ID:
Codes Authorized: 90791 90834 90837 90847 90846 96101		

I authorize the provider rendering the service to submit claims to my health insurance company for all covered services rendered in this practice and authorize and direct the health insurance company to issue payment directly to the provider. I authorize my provider to furnish complete information to my health insurance company regarding services rendered.

Signature:____

Date:_______________________