

John Migueis, LCSW Registration Form

Client Information:

Last Name _____ First _____ MI _____

Date of Birth ____/____/____ Sex: M / F

Social Security # _____ Relationship status _____

Address _____ City _____ State & Zip _____

Employer _____
Occupation _____

Home phone # _____

Work Phone # _____

Cell Phone # _____

Emergency contact _____

Phone # _____

I authorize John Migueis, LCSW to contact the above named emergency contact in case of an emergency.(please initial) _____

PLEASE COMPLETE THIS SECTION IF CLIENT IS A MINOR

Parent(s)/Guardian(s): _____ MI _____

Date of Birth ____/____/____ Sex: M / F

Social Security # _____ Relationship to client _____

Address _____ City _____ State & Zip _____

Employer _____ Occupation _____

Home phone # _____ Work Phone # _____

Cell Phone # _____

PLEASE COMPLETE THIS SECTION IF USING INSURANCE*

Primary Insurance Company _____

Effective Date of Coverage _____

Insurance Co. Address _____

Circle type of coverage: Family / Individual

Group # _____ Subscriber # _____

Subscriber SS # _____

Name of Policyholder _____

Relationship to client _____

Address of Policyholder (if different from client) _____

Employer _____ Occupation _____ DOB of

Policyholder ____/____/____

***If using insurance, please give your card and the policyholder's photo ID to your therapist or the receptionist so copies can be made for our billing office.**

Your initial evaluation fee is \$ 100 ; your session fee is \$ 100 .

As a courtesy, we will file for reimbursement with your insurance carrier; **however, the ultimate responsibility for payment on your account is the client's or the client's parent/guardian. We not accept responsibility for collection of your claim or negotiating a settlement on a disputed claim.** The client will receive a monthly statement indicating all charges and payments

When necessary to cancel an appointment, please do so at least 24hrs in advance. Please leave a cancellation message directly in the confidential voice mail of John Migueis. A client or client's parent/guardian is personally responsible for the professional fee when an appointment is missed and/or not properly canceled, except in extenuating circumstances. Insurance will not reimburse for missed appointments.

If Insurance payment is not received within 37 days of the session date, the client credit card on file will be charged. If the client credit card is not on file, client will pay by check within 30 days of session date.

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance carrier to make payments directly to John Migueis, LCSW for psychotherapy services. I accept personal responsibility for the deductible amount and for any balance outstanding after payment of such benefits. I further understand that copies of this authorization will be used in subsequent billings and that they be accepted as valid as the original.

Client Signature (or parent/guardian) _____ Date _____