Cindy Jackson, M.Ed, LPC, NCC

REGISTRATION FORM

PATIENT
NAME:_____
(LAST) (MIDDLE) (FIRST)

ADDRESS: _____
(STREET) (APT. #)

_____
(CITY) (STATE) (ZIP CODE)

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE:_____

CELL PHONE CARRIER:_____ E-MAIL:_____

SOCIAL SECURITY #:_____ SEX: M F MARITAL STATUS: S M D W

BIRTHDATE: _____ AGE: _____

SPOUSES DOB:(if primary on insurance) _____

EMPLOYER: _____

SPOUSE EMPLOYER (if primary on insurance)_____

IN CASE OF EMERGENCY NOTIFY:
NAME: _____ RELATIONSHIP_____
HOME PHONE: _____ CELL PHONE: _____

GUARANTOR AGREEMENT: I agree to take full responsibility for the entire amount due for any and all services rendered by Cindy Jackson, M.Ed, LPC. If she is contracted with my insurance company, I authorize and request my insurance to pay directly to Cindy Jackson LPC the amount due for services rendered to my dependents or me. As a result, I will be responsible only for the co-pay, deductible, and non-covered services as determined by the insurance plan.

SIGNITURE: _____ **DATE:**_____
CLIENT/GUARANTOR

IF YOU ARE GIVING PERMISSION TO BILL YOUR INSURANCE PLAN, PLEASE READ AND SIGN THE FOLLOWING RELEASE OF INFORMATION: I authorize the

release of any mental health information necessary to process insurance claims for services rendered to me or my dependents. This consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this release will be null and void six months after the final payment has been received on my account. This consent is subject to state and federal confidentiality requirements.

SIGNATURE: _____ **DATE:**_____

PATIENT/GUARANTOR