**New Transitions Counseling Center, Ltd.**
**415 South Creekside Drive, Suite 107**
**Palatine, IL 60074**

# REGISTRATION FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

| Client's **Last Name**: | **First:** | **Middle**: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? | If not, what is your legal name? | Social Security no.: | **Birth date:** | Age: | Sex: |
|---|---|---|---|---|---|
| ❑ ❑ Yes No | ❑ M ❑ F | | / / | | |

| Street address: | E-mail Address: | Home phone #: ( ) |
|---|---|---|

| City: | State: | ZIP Code: | Cell phone #: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Work phone #: ( ) |
|---|---|---|

| Chose clinic because/Referred to clinic by (please check one box): | ❑ Dr. | ❑ Insurance Plan | ❑ Hospital |
|---|---|---|---|

| ❑ Family | ❑ Friend | ❑ Website/Internet | ❑ Yellow Pages | ❑ Other |
|---|---|---|---|---|

## INSURANCE INFORMATION

(Please give your insurance card to the therapist.)

| Person responsible for account: | Birth date: / / | Address (if different): | Home phone #: ( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer address: | Employer phone #: ( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No Self-Pay

| **Primary Insurance Company:** | | | | | |
|---|---|---|---|---|---|
| **Subscriber's Name:** | Subscriber's S.S. no.: | **Birth date:** / / | **Group #:** | **Policy #:** | Co-payment: $ |

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

| Name of secondary insurance (if applicable): | Subscriber's name: | Group #: | Policy #: |
|---|---|---|---|

| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other |
|---|---|---|---|---|

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone #: ( ) | Cell/Work phone #: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Transitions Counseling Center, Ltd. I understand that I am financially responsible for any balance not paid by insurance. I also authorize New Transitions Counseling Center, Ltd. or insurance company to release any information required to process my claims.

_____ _____

*Patient/Guardian signature* *Date*