Omaha Family Counseling Place

1710 N. 144 Street, Suite 4
Omaha, NE 68154-4715
402.915.1061

Registration Information

PERSONAL INFORMATION:
(Complete on behalf of the Patient/Client)

Name: _____DOB: _____ Male ☐ Female ☐
First Middle Last
Street Address: _____ City/State/Zip: _____

Home Phone: _____Cell: _____Work:_____
OK to call? Y N **OK** to call? Y N **OK** to call? Y N

email address: _____ Emergency contact: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced☐ Widowed ☐

If the client is a minor whose parents are divorced, which parent has legal custody?_____

_____

Additional Information: _____

How did you hear about me? _____

PERSON(s) RESPONSIBLE FOR THIS ACCOUNT:

***We cannot bill a 'third-party' without their signature on file ***

Name: _____DOB: _____ Phone: _____

Address: _____ SS#: _____

Family Physician: _____Phone: _____
Medication/Dosage: _____
Has client had previous counseling? _____

INSURANCE: **Are you using an EAP? Yes No** *** **Do you wish this office to file claims? Yes No**

Primary Insurance (Name & Address): _____

Subscriber Name:_____ DOB: _____

ID#: _____ Group#: _____ Employer: _____

Secondary Insurance (Name & address): _____

Subscriber Name:_____ DOB: _____

ID#: _____ Group#: _____Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS:

☐ I hereby authorize **Omaha Family Counseling Place** to release information necessary to process insurance claims relating to my treatment.

☐ I authorize my insurance company to pay directly to **Omaha Family Counseling Place** all benefits otherwise payable to me.

☐ **I will be responsible for all expenses related to treatment not paid under this plan(s*).***

Client signature: _____ Date: _____

Guardian (if minor): _____ Witness: _____