Morningside Counseling Center

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP______________________________

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ TG ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose MCC Because/Referred to MCC by (Please check one box) ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________

Other Family Members Seen Here ______________________________

INSURANCE INFORMATION (NOTE: MCC DOES NOT ACCEPT ASSIGNMENT OF BENEFITS)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a client here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ______________________________

❑ Other ____________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Client'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 Client	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Erin K. Swenson, Th.M., Ph.D., or insurance company to release any information required to process my claims.

X ______________________________

CLIENT/GUARDIAN SIGNATURE DATE