Please provide your photo ID and insurance card for us to copy

Judith Rose Wilson, LCSW-C

PLEASE PRINT Patient Registration Information

LAST NAME	FIRST NAME	MIDDLE INITIAL

DOB - MM/DD/YYYY	AGE	GENDER	SSN
		☐Male ☐Female ☐Other	

MARITAL STATUS

☐Single ☐Married, living together ☐Married, not living together ☐Cohabiting with Partner ☐Separated ☐Divorced ☐Widowed ☐Other, explain:

EMPLOYMENT/STUDENT STATUS *(check on from each category, if applicable)*

Employment Status	Student Status
☐Unemployed, not looking for work ☐Unemployed, looking for work ☐FT employed ☐PT employed ☐Retired ☐On Welfare ☐Soc Sec Disability ☐Self-Employed	☐Part-Time ☐Full-Time ☐Not a student

Employer Name, if employed:	

HOME ADDRESS

Street Address *(apt #, if applicable)*	City, State & Zip code

CONTACT INFORMATION

Home Phone	**Work Phone**	**Cell Phone**

Email(s)	Preferred Method of Communication
1)	☐ Home Phone ☐Work Phone ☐Cell Phone
2)	Would you like to receive appointment reminders via email or text? ☐Yes ☐No

Please give us your insurance card(s) to copy for your file

INSURANCE INFORMATION ***if not using insurance, skip to responsible party section***

Insurance Company Name	Policy/Plan Number	Group Number

If using an EAP (Employee Assistance Plan), Please indicate the EAP info	EAP Carrier Name:	# of Approved EAP Visits:	EAP Auth Dates: Start:
	EAP Approval Code:		End:

RESPONSIBLE PARTY ☐Same as Patient

This Is the person that is responsible for any unpaid balances (copays, coinsurance and/or deductibles)

Name:		Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other, explain
DOB:	SS#	Address ☐ *check here if same as patient*

Authorization and Assignment: I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to **Judith Rose Wilson, LCSW-C**. I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company or other organization. I also agree that if my account is referred to a third party for 60 days past due, I will be responsible for the collection agency fee of 35% plus 19% interest and the balance due. *You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that Judith Rose Wilson, LCSW-C or representative may contact me/us as described above.*

⊗ _____ _____

Signature of Patient (Parent/Guardian if minor child) Date