Patient Registration – Dr. Marji Prefontaine, LPCC

Client Name: ___________________________________ Date of Birth: ____________________________

Email Address: ____Age: ____________________

Gender: ____Male ____Female Marital Status: ____ Single ____ Married ____ Other

Malling Address: ____

City: ___________________________ State: ____________________ Zip Code: _________________

Cell Phone: ________________________________ Home Phone: _______________________________

Employer Name: ____ Phone: _______________________

Gross Family Income: ____________________________ Education Level: _______________________

Emergency Contact: _________________________________ Relationship: _______________________

Phone: ____

Primary reason for seeking services: ____

Secondary reason for seeking services: ____

Medications: (include over the counter drugs and supplements): _________________________________

____

Family Members (Spouse, Children):

Name	Age	Grade/Occupation	Relationship	Living at home?
				___ Yes ___ No
				___ Yes ___ No
				___ Yes ___ No
				___ Yes ___ No

Clients Family of Origin (Mother, Father, Brothers, Sisters):

Name	Age	Grade/Occupation	Relationship	Living at home?
				___ Yes ___ No
				___ Yes ___ No
				___ Yes ___ No
				___ Yes ___ No

Responsible Party for Billing (If other than Patient):

Name: ____ Relationship: _______________________

Date of Birth: ______________________________________ Phone: ____________________________

Insurance Company: _________________________________ Phone: ____________________________

Member ID: _________________________________ Group Number: ___________________________

How did you find us?

_____ Friend/Family _____ Internet _____ Physician Referral _____________________________ Other

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PCP Physician Information:

Name: ______________________________________ Phone: _________________ Fax: _________________

Address: ____

Permission to contact/and or coordinate services as needed with PCP: __________ Yes __________ No

Signature: ____ Date: __________________________

Disclosures and HIPAA (Initial on each line)

Appointment Policy

_________ If it is necessary to change your appointment, our office requires 48-hour notice.

_________ Rescheduling an appointment with less than 48 hours prior notice will be considered inadequate time for our office to place a patient in your reserved time slot.

_________Failure to provide 48 hours' notice will result in a charge of $50.00:

_________ Please call if you have a cold or communicable disease and we will discuss options. The office accepts messages 24/7

_________Cancellations via email will not be accepted, they **must** be communicated via text at 505-614-6614.

Signature: ____ Date: __________________________

Filing of Insurance

_________ Total payment is expected at time of service.

_________ Our office will bill your primary insurance, as a patient, you agree to and guarantee to be responsible for, and to settle any remaining account balances including, but not limited to: co-pays, deductibles, and amounts denied by insurance.

_________ By signing this agreement, the patient or responsible party agrees to be responsible for all feeds and understands that any remaining feeds due will be charged to the credit card on file.

_________ I understand that final sessions must be face to face, and there is a wrap-up session required upon completion of therapy.

Signature: ____ Date: __________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read a copy of this medial practice's notice of Privacy Practices. I further acknowledge that a copy of the current policy is available upon request.

Signature: ____ Date: __________________________

Print Name: ____ Date: __________________________