Trellis Counseling, LLC

Date

Registration Form

Client Information

Client Name
Last Name First Name Initial

Date of Birth

Street Address

Primary Phone

Alternate Phone

City State Zip

Email

☐ OK to leave messages/texts at above numbers

Gender ☐ Female ☐ Male ☐ Non Binary

Age

Relationship Status

Employer

Occupation

Referred By

May we acknowledge this referral? ☐ Yes ☐ No

Emergency Contact

Emergency Phone

Primary Insurance or EAP information

Primary Insurance Company *or* EAP Services provider

Phone

Ins Claims Address

Group/Account #

City State Zip

Policy / Member ID or **EAP Authorization code**

Policy Holder Information: (if the client is not the employee/policy holder)

Name
Last Name First Name Initial

Date of Birth

Street Address

Relationship

Employer

City State Zip

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits.

Client E-Signature Relationship Date