Ann James Counseling, L.L.C.
1639. N. Alpine Road Suite 204
Rockford, IL 61107
(779) 423-0275

REGISTRATION

Date:_____

Patient Name:_____

Street Address:_____

City, State & Zip Code:_____

Date of Birth:_____ Age:_____ Ethnicity:_____

Telephone: Home:_____ Cell:_____ Work:_____

Email Address:_____

I authorize scheduling reminders: ____ Text ___ Email

Name of Primary Care Physician/Pediatrician:_____

☐ I authorize Ann James Counseling, LLC to exchange Private Health Care Information with my Primary Care Physician/Pediatrician.

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

For Children and Adolescents, Please complete the following:

Father's Name:_____ Mother's Name:_____

Who is Legal Guardian?_____

Name of School Attended:_____ Grade in School:_____

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Name of Primary Insurer:_____

Name of Secondary Insurer:_____

Are you the Primary Insured? ☐ Yes ☐ No If no, please answer the following:

Primary Insured's Name:_____ Relationship:_____

Date of Birth:_____

Employed by:_____

Street address:_____

City:_____ State:_____ Zip code:_____

Name of person financially responsible for the account:_____

Address:_____

Phone Number :_____

Would you like us to keep a credit card on file in our secure, encrypted system for copays/co-insurance? Yes No
Credit Card # _____ Exp:___/___ CVS:_____
Signature to authorize Ann James Counseling, LLC to use credit card on file to pay account balances as they accrue following insurance submission. Monthly statements will be sent out.

_____
Signature Date

In case of emergency, who should be notified?_____

Relationship:_____ Telephone:_____

How did you learn about Ann James Counseling, L.L.C.? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Ann James Counseling, L.L.C. all medical benefits for services rendered. I understand that I am financially responsible for all charges whether paid or unpaid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits and also to facilitate further medical care with other physicians. I authorize the use of this signature on all of my insurance submissions.

_____
SIGNATURE