Elliott Strick, MA, LMFT West Hartford Therapy Center LLC

10 North Main Street, Suite 214, West Hartford, CT 06107

CLIENT REGISTRATION INFORMATION (**PLEASE PRINT**)

Name _____ Date _____

Address _____

_____

Phone: Home _____ Cell _____ Work _____

Preferred phone _____ May I leave a message _____ Email _____

Date of Birth _____ Name of Employer _____

Name of Partner or Spouse _____

Address (if different) _____

_____

Phone: Home _____ Cell _____ Work _____

Preferred phone _____ May I leave a message _____ Email _____

Date of Birth _____ Name of Employer _____

Person to contact in case of emergency:

Name _____ Relationship _____

Phone _____

Please list children or other persons living with you:

Name(s)_____ Age _____ Relationship _____

_____ _____ _____

_____ _____ _____

Continued . . .

Who referred you to me? _____ May I thank them? _____

Insurance Info: (please bring insurance card so I can make a copy)

Insured's name _____ ID# _____ Group # _____

Insurance Carrier_____

I authorize payments under my insurance program to be made directly to me or to the above provider for any services furnished by this provider. I agree that if the amount is insufficient to cover the bill, I will be responsible for payment of the difference, and, if my treatment is not covered by my insurance policy, I will be responsible to the provider for the entire amount.

I understand and agree that payment to Elliott Strick for services rendered to me is due at the conclusion of each therapy session. My fee is based upon a therapy session that is approximately 55 minutes. Additional time or a shorter session would need to be negotiated in advance of a scheduled session. I agree that I am responsible for payment for late cancellations or for appointments I miss (please read and sign separate missed appointment policy form).

Signature _____ Date _____

_____ Date _____