NEW PATIENT REGISTRATION

Last Name ______________________ **First name**_____________________ **Middle Initial**________________________

Address__________________________________ **City**_______________**State**______ **Zip**________________________

Cell (____**)**___________________**Home Telephone (**_____**)**__________________ **Work (**_____**)**___________________

Date of Birth__________________ **E-mail Address**____
MM DD YYYY

May we call you at home? o Yes o No Okay to leave a message at home? o Yes o No
May we call your cell ? o Yes o No Okay to leave a message on cell? o Yes o No
May we text your cell? o Yes o No

Who may we thank for your referral? ____________________***How did you find our Website?***__________________

Relationship Status: Married / Partnered (yrs:______ mos:______)

In a Relationship more than 6 months (yrs:______ mos:______) Separated ________ Divorced ________

Occupation:__________________________________ Type of Business:_______________________________________

Person to notify in the event of an emergency: ____
Emergency contact's relationship to you: __________________Contact's phone: ______________

a) Payment is due at the time of session or when services are rendered. X ______

b) We do not accept or process insurance including Medicare. X ______

c) If I file a claim on my own and the insurance carrier requests information directly from this provider or SHC, it is understood that this provider or SHC will not respond in any way to this request but will wait to hear from me, the patient or insured, and receive written permission to respond on my behalf. X______

d) 24 hours notification -1 business day- is required to cancel or change an appointment. I understand that if changes are made within this 24 hour period then I will be charged the full therapy hour rate. X______

PRIVACY PRACTICES ACKNOWLEDGMENT: I have received the Notice of Privacy Practices and Informed Consent form and have been provided an opportunity to read and review it. X______

I consent to consultation and/or treatment for the above mentioned person(s):

X_________________________________	X______________	X_________________________________	X_____________
Signature of Patient	**Today's Date**	**Signature of Spouse, Partner, or Responsible Party**	**Today's Date**