

Kettle Moraine Counseling Services

Client Registration

Client's Name _____ Maiden Name: _____
(Last) (First) (M.I.)

Address _____
(Number and Street) (City) (State) (Zip)

Home Phone Number _____ Work Phone Number _____

Mobile Phone Number _____ Email _____

Date of Birth _____ Social Security # _____

Marital Status: M S W D Separated Spouse's Name _____

Employer _____

IF CLIENT IS UNDER 18:

Name of Parent or Guardian _____

Address of Parent or Guardian _____
(Number and Street) (City) (State) (Zip)

Home Phone Number _____ Work Phone Number _____

Mobile Phone Number _____ Email _____

INSURANCE INFORMATION-

Primary Insurance _____ Secondary Insurance _____

Member # _____ Member # _____

Group # _____ Group # _____

Name of Insured _____ Name of Insured _____

Insured SS# _____ Insured SS# _____

Insured DOB _____ Insured DOB _____

Co-pay Amount _____ Co-pay Amount _____

Employer _____ Employer _____

How were you referred to us?

I hereby authorize to release any medical information necessary to process claims and I agree to assign insurance payment directly to the clinic. I certify that the insurance information supplied is correct and understand I will be responsible for any services not covered by insurance. I also understand that any co-pay I have with my insurance plan is **due at the time of service.**

Signature _____ Date _____