Western Carolina Counseling Services, P.A.
103 Sylvan Heights
Sylva NC 28779

Client Registration Form

Please provide complete information. Filling out this form will expedite the processing of your insurance claim.

Client Information:

Name_____ Date of Birth _____

Address _____

_____

Phone Number_____ Cell Phone #:_____ Work #:_____

May we contact all of the above numbers in effort to reach you? ( ) Yes ( ) No If no, please circle #(s) for contact

Email address _____ May we contact you at this email address? ( ) Yes ( ) No

Single ( ) Married ( ) Significant Other ( ) Separated ( ) Referral Source_____

Primary Physician: _____ Employer:_____

Insurance Information: (Please fill out if insured is other than yourself.)

Name of Policy Holder_____ Sex: F ( ) M ( )

Address (only if different from client)_____

Phone Number_____

Date of Birth_____ Insured's SS#_____

Relationship to policy holder: Spouse_____ Child_____ Other_____

Financial Policy: Payment of deductibles and co-payments is expected at the time of service. Cash, checks, and credit cards are acceptable methods of payment. Insurance claims for each service date will be submitted to your insurance company twice, after which time the responsibility for payment will become yours. Self –Pay clients are responsible for payment after each session.

Authorization & Assignment: I hereby authorize this provider to release any information required to process this claim. I give permission for Western Carolina Counseling Services to file claims with my insurance company for all services provided. I authorize payment directly to the billing office of this provider for the medical benefits, if any, payable to me for services. I understand that I am financially responsible for the charges not covered by insurance. I am responsible for knowing my policy's yearly deduction and co-pay amount and if authorization is required from the insurance carrier.

_____ _____

Signature **Date**