NEDRA VOORHIES, D.MIN., LPC

(Please Print)

CLIENT REGISTRATION SHEET

TODAY'S DATE:		

CLIENT INFORMATION

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address:	City:		State:		ZIP Code:
Home phone ( )	Cell/Other contact ( )	Social Security	Birth Date: / /		Sex: M F
Employer:	Occupation:		Work phone ( )		
Street Address:	City:		State:		ZIP Code:
Email address:					
Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician		Contact ( )		

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone ( )	Cell phone ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Home phone no.: **(if different)** ( )	Cell/Other contact ( )	Social Security	Birth Date: / /		Sex: ❑ M ❑ F
Insurance Company:	Insurance Billing Address:				Insurance phone no.: ( )
Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

EAP INFORMATION

EAP Company	EAP Authorization #		Company		
Value Options	Compsych	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the counselor. I understand that I am financially responsible for any balance. I also authorize Nedra Voorhies, LCPC, those acting on the practice's behalf, and my insurance company to release any information required to process my claims. **PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the full session amount of $75.00. Thank you for your cooperation.**

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

Patient/Guardian signature _____ Date _____