THE WELLNESS INSTITUTE OF MICHIGAN

KAREN GALLAGHER LMSW,ACSW
REGISTRATION FORM

THERAPIST: ______________________________ APPT DATE: ______________________________

REFERRAL SOURCE: ____

PATIENT NAME: ______________________________ DATE OF BIRTH ______________________
ADDRESS: ____
CITY: ______________________________ STATE: __________ ZIP CODE: ____________________
SS#: ______________________________ EMPLOYER: ______________________________
PHONE: ______________________________ WORK PHONE: ______________________________

SEX: **FEMALE** **MALE** MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

RESPONSIBLE PARTY: ______________________________ SS#: ______________________
ADDRESS: ______________________________ CITY/STATE: ____________________ZIP CODE: __________
PHONE: ______________________________ WORK PHONE: ______________________________

INSURANCE #1: ______________________________POLICY#: ______________________
GROUP #: ______________________ EMPLOYER: ______________________________
POLICY HOLDER: ______________________________ SS#: ______________________________
PHONE: ______________________________ INSURED D.O.B.: ______________________________

INSURANCE #2 : ______________________________ POLICY#: ______________________
GROUP #: ______________________ EMPLOYER: ______________________________
POLICY HOLDER: ____
PHONE: ______________________________ INSURED D.O.B.: ______________________________

---EMERGENCY CONTACT---

NAME: ______________________________ RELATIONSHIP: ______________________
PHONE: ______________________________ ALT. PHONE: ______________________________

AUTHORIZATION FOR TREATMENT AND BILLING SERVICES

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company for paper & electronic billing and your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize the therapist's billing company to file for benefits on my behalf for the medical services rendered. Insurance payments shall be made directly to the therapist. If I have Medicare insurance, I authorize the therapist to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the therapist by written request.

I consent to mental health counseling, neuropsychological or psychological testing, or substance abuse treatment at the Karen Gallagher, LMSW, ACSW, Professional Counseling Services, LLC offices.

SIGNATURE ______________________________________ **DATE** ______________________

Karen Gallagher, LMSW, ACSW   Professional Counseling Services
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