SAMANTHA WIDMAN, LMFT

PSYCHOTHERAPY

Registration Form

Client Information

Client Legal Name_____ Date of Birth_____

Street Address_____Home Phone_____

City_____State_____Zip_____Other Phone_____

Emergency Contact_____ Emergency Phone_____

Age_____ Marital Status: Single Married Partnered Divorced Separated Widowed

Other Preferred Pronouns/Name_____ Email Address_____

Employer_____Occupation_____

Assignment and Release

I the undersigned certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the health care provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party (printed): _____

Responsible Party (signature): _____

Relationship to Patient: _____ Date: _____

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