

# Heritage Counseling Associates

555 Dayton St., Ste C  
Edmonds, WA 98020  
Office: 425-774-4673  
Fax: 425-774-0690

## Client Registration—Please Print

Client \_\_\_\_\_  
Last name First Name Initial  Male  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age Social Security # \_\_\_\_\_  Female

(if client is under 18) Grade \_\_\_\_\_ School \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Information for Spouse, or Parent/Guardian (if client is minor)

Name \_\_\_\_\_  Male  
Last name First Name Initial  Female  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Spouse' Name \_\_\_\_\_ Birthdate \_\_\_\_\_

How were you referred to this office? \_\_\_\_\_

Your Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact? \_\_\_\_\_ Phone \_\_\_\_\_

### PERSON RESPONSIBLE FOR BILL, IF NOT CLIENT

Name \_\_\_\_\_ Relationship to client \_\_\_\_\_  
Address \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Co. \_\_\_\_\_ Client's Relationship to Subscriber  Self  Spouse  Dependent  
Subscriber \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Subscriber's ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Is insurance authorization needed? \_\_\_\_\_ Have you obtained? \_\_\_\_\_ What is the amount of your co-payment? \_\_\_\_\_

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider of service. I am financially responsible for any balance due. I also authorize the doctor/provider or insurance company to release any information required for this claim.

Please \_\_\_\_\_

Sign \_\_\_\_\_ Client or Guarantor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Important**

Payment is expected at the time of service. All balances due are payable within 30 days. Accounts with balances over 30 days will be charged a finance charge of 1% per month. Missed appointments and cancellations without 24 hours advanced notice will be charged.

Initial \_\_\_\_\_