MN Couple Therapy Center
Client Registration
1611 County Road B, Suite 204
Phone: 651-340-4597

General Information
Client name _____DOB: _____Age: _____Today's date: _____

SSN _____ Sex: __F __M Spouse or partner _____

If under 16, please give parent(s) name(s)_____

Marital Status S M D W Other_____

Current status: Student Employed Unemployed Retired Other: _____

If student, are you Full Time or Part Time? FT PT School attending: _____

If working, please give Occupation and Place of Employment _____

Emergency contact _____Relationship _____

Emergency contact Phone Number _____ Alternative Phone Number _____

If person filling out form is not client, check here: What is your relationship to client? _____

Address & Contact Information
Home Address_____

City_____State_____ Zip_____

If you have any special instructions regarding how you would like mailed communications to be handled to ensure your confidentiality, please detail here: _____
_____

Home phone _____Okay to call? Y N Okay to leave message? Y N

Cell phone _____ _____Okay to call? Y N Okay to leave message? Y N

Work phone _____ Okay to call? Y N Okay to leave message? Y N

Email _____Okay to email? Y N

Any special instructions when calling, leaving messages or emailing? _____
_____

Insurance Information
Insurance Carrier: _____Policy ID #_____Group #_____

Policy Holder Name:_____ Policy Holder DOB:_____ SSN _____

I hereby authorize my provider at Minnesota Renewal Center to furnish the above-named insurance company all information they may request concerning my present diagnosis and treatment. I hereby assign to my provider the insurance proceeds to be credited against the total fee for service due on my account. I understand and agree that I am financially responsible for all charges whether or not they are covered by insurance.

Client Signature _____ Date _____ (_____)