CLIENT REGISTRATION FORM

CREEKSIDE COLLABORATIVE THERAPY

6093 S. Quebec #100, Centennial CO 80111

Client's Name: _____ D.O.B. _____

Address: _____ SS#: _____

_____

Phone: _____ (home) Is it okay to leave a message?

Yes No

Phone: _____ (cell) Is it okay to leave a message?

Yes No

Email: _____ Is it okay to send an email?

Yes No

Name of parent: _____ D.O.B. _____
(If child)

Address: _____

_____

Phone: _____ (home) Is it okay to leave a message?

Yes No

Phone: _____ (cell) Is it okay to leave a message?

Yes No

Email: _____ Is it okay to send an email?

Yes No

Name of other parent: _____ D.O.B. _____
(If child)

Address: _____

_____

Phone: _____ (home) Is it okay to leave a message?

Yes No

Phone: _____ (cell) Is it okay to leave a message?

Yes No

Email: _____ Is it okay to send an email?

Yes No

Signature of Person Completing This Form: _____

Note on Legal Custody: If parents are legally separated or divorced, you MUST submit with this informed consent the documentation giving you the legal right to pursue medical or psychiatric treatment. Both parents may also complete forms for treatment in lieu of this requirement.

Please provide your insurance information if you would like us to bill them for your sessions.

Insurance Information (primary):

Name of Insurance Company: _____
Name of Insured: _____
Employer: _____
Group #: _____
Policy #: _____
Customer Service #: _____

Benefits (will be completed by Creekside):
Number of sessions available per year: _____
Number of authorized sessions: _____
Authorizations active until: _____
Copay: _____
Deductible (if any): _____

Insurance Information (secondary):

Name of Insurance Company: _____
Name of Insured: _____
Employer: _____
Group #: _____
Policy #: _____
Customer Service #: _____

Benefits (will be completed by Creekside):
Number of sessions available per year: _____
Number of authorized sessions: _____
Authorizations active until: _____
Copay: _____
Deductible (if any): _____