Registration Form

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Client's name: _____
First Middle Last

Home address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Sex: ___ Marital status: _____
Home phone: _____ Work phone: _____
Cell phone: _____
Employer: _____
Work address: _____
E-mail address: _____
Spouse: _____ Spouse's Employer: _____

Financially responsible person (if other than yourself): _____

Who referred you for services? _____

Primary Care Physician: _____
Previous mental health care: _____
Provider or facility name

Medications presently being taken, with dosages: _____
_____
Current medical problems: _____
_____
Health care plan name: _____
Address:_____
ID#: _____ Group#: _____Subscriber: _____
Other plans covering you: _____

Read and sign if using health care plan to help pay for these services:

I, _____, authorize David L. Kupfer, Ph.D. to apply for benefits on my behalf for services rendered. I request that payment be made either directly to David L. Kupfer, Ph.D., if he is an in-network provider, or to me if he is not. I certify that the information provided regarding health care coverage is accurate. I authorize release of any necessary information to my health care plan to enable payment of claims. A copy of this authorization and assignment agreement can be used and considered valid. This will remain in effect until revoked by me in writing. I understand that I am legally responsible for all charges, whether or not paid by my health care plan. While Dr. Kupfer's office may file for payment from certain health care plans, I understand that I am still responsible for full payment of my fees and for understanding my coverage. If Dr. Kupfer's office does not file for payment from my health care plan, I understand that I can send in his Statement for Professional Services (accompanied by a claim form) to my health care plan for them to reimburse me for payment I have made to his office. I understand that the content of our discussions will remain totally confidential unless I give written permission for the release of such information.

Signature: _____ Date: _____

For all clients to read and sign:

Payment is expected at the time of the session. If I wish to make other arrangements for payment, I am aware that I must talk to Dr. Kupfer about it in advance. Twenty-four hours notice is requested when I have to cancel an appointment. Dr. Kupfer reserves the right to bill me for the entire cost of the scheduled session for any scheduled session that I miss or cancel with less than 24 hours notice. I understand that my health care plan will not pay for these charges. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs, 12% annual interest accrual, and attorney fees. I also understand that I will be charged $25 for any checks returned by the bank.

_____ _____

Client or responsible party Date _

_____ _____

Therapist Date