

Dr. Kathleen Young, Psy.D.
Affirming Alternatives Psychological Services

Client Registration Form

Today's Date: _____

CLIENT INFORMATION

SS#: _____ Date of Birth: _____ Sex: _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Best number: (_____) _____ Leave a message? Y N

Employer: _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT):

Billing Address with City/Zip Code: _____

Phone# Hm: _____ DOB: _____

Relationship to patient: _____

Employer: _____ SS#: _____

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

Name of Insurance Company: _____

Address/Phone: _____

Subscriber: _____

Relationship to patient: _____

Policy#: _____ Group#: _____ ID#: _____

Authorization #: _____

REFERRAL SOURCE

Name of person referring you to this office: _____ May I thank this person
for referring you? YES [] NO []

SIGNATURE/AGREEMENT

I, _____, have been given handouts explaining the services and policies
of this office. I have had the opportunity to discuss any concerns or questions that I might have.
I understand my rights and my responsibilities as outlined in the above-mentioned handouts

CLIENT SIGNATURE: _____ Date: _____

Witness Signature: _____ Date: _____