Dr. Heather Therapy, PLLC

Registration Form

1829 East Franklin Street, Unit 100H, Chapel Hill, NC 27514 - 919-228-9227 - www.DrHeatherTherapy.com

Client's Full Name (Last, first, middle):		
Client's home address:		
City:	**State:**	**Zip:**
Client's birth date:	**Client's Sex (circle one):**	M F
If client is employed, circle one:	Full time	Part time
If client is a student, circle one:	Full time	Part time
Name(s) of client's parents/custodian/legal guardian *if applicable*:		
Client/Guardian home telephone #:	**Work #:**	**Cell #:**
Please circle where confidential messages may be left:	Home Work	Cell
Client/ Guardian Email Address *please print clearly*:		
Would you like to receive session reminders via email?	Yes No	
Would you like access to my client portal to view and request appointments?	Yes No	
***For minors*: If parents are separated/divorced, who has legal custody of this child? Joint contact name and phone, address, or email*: *please note in cases of joint custody both custodial parents must be informed of treatment for a minor		
Name and address of person to send bills (*if different from above*):		

Insurance Policy Information

Insured's name (last, first, middle):	**Insured's DOB:_____________**
Insured Address (if different than home address)**:**	
Client relationship to insured: Self Spouse Child Other (specify)	
Primary Insurance Co. Name:	
Policy Member ID # :	**Group # :**
Deductible Amount: ***Has deductible been met?*** Y N	**Co-payment Amount:** **Eff. Date of Policy:**
Does policy require that mental health benefits be pre-authorized? YES NO **If yes, please provide authorization number:**	
Is the policyholder insured under employer's health plan (circle one)? YES NO	
Employer name:	

Please confirm your mental health benefits & provide insurance card for photocopy. Thank you!

I request and authorize Dr. Heather Therapy, PLLC to provide evaluation and/or treatment for myself and/or my child. I hereby authorize the release to my insurance company of any medical information necessary to process claims for services provided by Heather Norman-Scott, PhD. I authorize payment of medical benefits to Dr. Heather Therapy, PLLC. I agree that I am responsible for any balance not reimbursed by my insurance company. I understand a collection and/or finance charge may be applied to any balance over 90 days past due.

_______________________________________ ____________________

Signature of Client or Responsible Party Date