Registration Form

Please print, fill in and bring with you to your first appointment.

Client Information

Last Name: First Name: SS #:

Address: Email: (Optional)*

City: State: Zip Code:

Telephone #: Birthdate: Sex: Relationship Status:

Relationship to the Insured:

How did you learn about Institute for Change?

Insured Information

Last Name: First Name: SS#:

Address: Email:(Optional)*

City: State: Zip Code:

Telephone # Birthdate: Sex: Marital Status:

Employer Information

Company: Address:

City: State: Zip Code: Telephone #:

Insurance Carrier

Company: Address:

City: State: Zip Code: Telephone #:

Group #: ID

Primary Care Physician

Name: Address:

City: State: Zip Code: Telephone #:

Emergency Contact

Name: Address:

City: State: Zip Code: Telephone#:

Relationship:

Release of Authorization

I authorize the release of any medical information necessary to my insurance claim(s). I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of an original.

_____

Signed (Patient or Representative) Date

Assignment of Benefits

I authorize and request payment of medical benefits directly to my provider.

_____

Signed (Patient or Representative) Date

*☐ Check here if you would rather not receive periodic newsletters from IFC. We respect your privacy and will never give your email address to anyone.

For Office Use Only	Session Charge:	Copay if Applicable :	Diagnosis Code: