REGISTRATION FORM

Mailing Address: IFC, PO Box 289, Caldwell, NJ 07006

Client Information

Last Name: **First Name:** **Middle Initial:**

Address:_____ **Email:**_____

City:_____ **State:**_____ **Zip Code:**_____

Telephone #:_____ **Birthdate:**_____ **Sex:** **Relationship Status:**_____

Relationship to the Insured:_____

How did you learn about Institute for Change?

Name of IFC Clinician :_____

Insured Information

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **Email:**_____

City:_____ **State:**_____ **Zip Code:**_____

Telephone #_____ **Birthdate:**_____ **Sex:** **Relationship 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**

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