

Patient Registration – Dr. Marji Prefontaine, LPCC

Client Name: _____ Date of Birth: _____

Email Address: _____ Age: _____

Gender: ___ Male ___ Female Marital Status: ___ Single ___ Married ___ Other

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Employer Name: _____ Phone: _____

Gross Family Income: _____ Education Level: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Primary reason for seeking services: _____

Secondary reason for seeking services: _____

Medications: (include over the counter drugs and supplements): _____

Family Members (Spouse, Children):

Name	Age	Grade/Occupation	Relationship	Living at home?
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No

Clients Family of Origin (Mother, Father, Brothers, Sisters):

Name	Age	Grade/Occupation	Relationship	Living at home?
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No
_____	_____	_____	_____	___ Yes ___ No

Responsible Party for Billing (If other than Patient):

Name: _____ Relationship: _____

Date of Birth: _____ Phone: _____

Insurance Company: _____ Phone: _____

Member ID: _____ Group Number: _____

How did you find us?

___ Friend/Family ___ Internet ___ Physician Referral ___ Other

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PCP Physician Information:

Name: _____ Phone: _____ Fax: _____

Address: _____

Permission to contact/and or coordinate services as needed with PCP: _____ Yes _____ No

Signature: _____ Date: _____

Disclosures and HIPAA (Initial on each line)

Appointment Policy

_____ If it is necessary to change your appointment, our office requires 48-hour notice.

_____ Rescheduling an appointment with less than 48 hours prior notice will be considered inadequate time for our office to place a patient in your reserved time slot.

_____ Failure to provide 48 hours' notice will result in a charge of \$50.00:

_____ Please call if you have a cold or communicable disease and we will discuss options. The office accepts messages 24/7

_____ Cancellations via email will not be accepted, they **must** be communicated via text at 505-614-6614.

Signature: _____ Date: _____

Filing of Insurance

_____ Total payment is expected at time of service.

_____ Our office will bill your primary insurance, as a patient, you agree to and guarantee to be responsible for, and to settle any remaining account balances including, but not limited to: co-pays, deductibles, and amounts denied by insurance.

_____ By signing this agreement, the patient or responsible party agrees to be responsible for all fees and understands that any remaining fees due will be charged to the credit card on file.

_____ I understand that final sessions must be face to face, and there is a wrap-up session required upon completion of therapy.

Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read a copy of this medial practice's notice of Privacy Practices. I further acknowledge that a copy of the current policy is available upon request.

Signature: _____ Date: _____

Print Name: _____ Date: _____