Perrysburg Counseling Service, LLC
Client Registration Form

This information is exclusively used for the purposes of billing and treatment. The information you share with us will be kept confidential and only be used in the course of the business and treatment you consent to in our Provider Client Agreement.

Client Name (first, middle last): _____

DOB: _____ Age: _____ Gender: _____ Marital Status: _____ SSN: _____

Address (Client's primary residence): _____

City, State Zip: _____ Home Phone: _____

Cell Phone: _____ Client's or Parent's # ☐ Send me text appointment reminders.

Email address (please print clearly): _____

⇨ **REQUIRED.** Our billing system requires a valid email address. All statements and payment receipts are emailed. Please list the email address of the family member to whom these should be sent.

Emergency Contact or a Custodial Parent: _____

Relationship to Client: _____ Phone (if different): _____

If Minor:

Name of Responsible Party: _____ SSN: _____

(if different) Address: _____

Home Phone: _____ Cell Phone: _____

I authorize the treatment of my minor child. _____

Signature of Responsible Party listed above

Primary Insurance for Mental Health Services:

Ins. Co. _____ ID # _____ Group # _____

Policy Holder's Information: Name _____

DOB: _____ SSN: _____ Employer: _____

Secondary Insurance (if applicable):

Ins. Co. _____ ID # _____ Group # _____

Policy Holder's Information: Name _____

DOB: _____ SSN: _____ Employer: _____

Please present your insurance card to your counselor or bring a copy of the front & back of the card.

PLEASE READ AND SIGN

To avoid misunderstandings and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. If you choose to use your health insurance, we do our best to estimate your eligibility and benefits before your first visit. Like any medical service, actual amounts will not be known until we will bill your insurance claims for you**.** As you are ultimately the one financially responsible for the services you receive at PCS, we strongly encourage you to advocate for yourself and verify your benefits on your own prior to your first visit. You will only receive an emailed bill monthly for any unpaid services, which is due in full upon receipt. We accept payment in the form of cash, check, or credit card.

In the case of minor children, payment for services is due from the parent that initiates services. We cannot bill another party who has not consented to a payment agreement with this office

By signing below, I authorize payment of benefits from my insurance be paid directly to Perrysburg Counseling Services, LLC. I also authorize Perrysburg Counseling Services, LLC to release to my insurance company any and all information necessary for the processing of insurance claims.

I verify that I understand that I am ultimately responsible for payment in full of charges incurred.

Client/Parent/Legal Guardian Signature _____ Date: _____

Cancellation/No Show Policy:

By signing below, I understand that the fee for missing a scheduled appointment is $120.00 and is to be paid in full prior to the next appointment. I understand that I must provide at least 24 hours' notice to avoid being charged a late cancellation fee of $120.00.

Client/Parent/Legal Guardian Signature _____ Date: _____

PCS Staff Signature _____ Date: _____