Heather Morgan-Sowada, Ph.D, LMFT
Licensed Marriage and Family Therapist

Client Registration Information. Please complete the following:

Client Legal Name: ____
Affirming/Preferred name/nickname (if any): ________________________________
Assigned Gender at Birth: ______________________Identified Gender: ___________________
Pronouns (ex: she/her/hers; he/him/his; they/them/their; ze/zem/zir): _______________________
Marital Status: ☐ Married ☐ Single ☐ Other ______________ Birthdate: ___________________
Level of Education Completed: ________________________________
Employment: ☐ Employed ☐ Student ☐ Unemployed Employer: _____________________________
Home Address: ____
City: ____________________________ State: ______________ Zip Code: _________________
Primary Phone: _________________ ☐Cell ☐Home ☐Work Email: ___________________________________
Secondary Phone: ______________ ☐Cell ☐Home ☐Work Email:____________________________________
Spouse/Partner Name: ____ Birthdate: ________________
Name/Location of Client's Psychiatrist/Physician: ____

Complete for each additional client:
First and last Name: _______________________________________ Birth Date: ________________
Relationship to Client: _________________ Level of Education Completed: __________________
Employer: ______________________________________ Phone Number: _______________________
First and last Name: _______________________________________ Birth Date: ________________
Relationship to Client: _________________ Level of Education Completed: __________________
Employer: ______________________________________ Phone Number: _______________________

Complete if client is a minor:
Caregiver's Name: ______________________________________ Birth Date: ________________
Primary Phone: _________________ ☐Cell ☐Home ☐Work Email: ___________________________________
Secondary Phone: ______________ ☐Cell ☐Home ☐Work Email:____________________________________

Caregiver's Name: ______________________________________ Birth Date: ________________
Primary Phone: _________________ ☐Cell ☐Home ☐Work Email: ___________________________________
Secondary Phone: ______________ ☐Cell ☐Home ☐Work Email:____________________________________

Who is your emergency contact?
☐ Family ☐ Friend ☐ Spouse/Partner ☐ Child ☐ Other: Name:____________________________________
Primary Phone: _________________ ☐Cell ☐Home ☐Work Email: ___________________________________
Secondary Phone: ______________ ☐Cell ☐Home ☐Work Email:____________________________________

Client's Initials____________

Reason for seeking therapy services?

____
____
____

What are your strengths?

____
____
____

What are your goals of counseling?

____
____
____

Primary Insurance Information:
Insurance Type: ______________________________ Relationship to Insured: _________________
Insured's ID Number: ______________________________ Birth Date of Insured: _____________
Insured's Policy Group: ____________________________
Insured's Employer/School: _________________________
Insured's Plan Name: ______________________________
Effective Date: _______________________
Copay amount: _______________________
Deductible amount: ____________________
Responsible Party for Billing: ____

Secondary Insurance Information
Insurance Type: ____________________________ Relationship to Insured: _________________
Insured's ID Number: ______________________________ Birth Date of Insured: _____________
Insured's Policy Group: ____________________________
Insured's Employer/School: __________________________
Insured's Plan Name: _______________________________
Effective Date: _______________________
Copay amount: _______________________
Deductible amount: ____________________
Responsible Party for Billing: ____

Signature(s) ____ Date ______________

____ Date ______________

(IF THE PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN FOR THEM)

Signature: _______________________ Relationship to Patient _______________Date: ________

Signature: _______________________ Relationship to Patient _______________Date: ________

Client's Initials___________

Not sure what your insurance benefits are?

*****it is YOUR responsibility to know what your benefits are, what your deductible/co-pay/co-insurance is.**

Below are questions to ask when you call your insurance company:

***please bring this filled out to your first session

Do I have coverage for outpatient mental health billed as an office visit?

is the effective date of my policy?

Is pre-authorization required?

Is there a limit to the number of visits per year?

What will I pay at each visit?

Do I have a deductible?
    If yes, how much has been met?

Will the amount I pay at each visit change when the deductible is met?

Do I have an out of pocket max?
    If yes, how much has been met?

Will the amount I pay at each visit change when the out of pocket max is met?

Where should the office send my claims? (claims address):

Client's Initials____________