

**NEW GROWTH
COUNSELING SERVICES
CLIENT REGISTRATION**

**430 E Lauridsen Blvd.
Port Angeles, WA 98362
360-457-1610**

**502 S Still Rd, Ste 102
Sequim, WA 98382
360-457-1610**

Please Print

DATE _____

NAME OF CLIENT _____ GENDER _____

BIRTHDATE _____

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

REFERRED BY _____ HIGHEST LEVEL OF EDUCATION COMPLETED _____

IN CASE OF EMERGENCY PLEASE CONTACT _____ PHONE _____

RELATIONSHIP _____

PRIMARY PHYSICIAN _____

CURRENT MEDICATIONS _____

NAME OF PERSONS AT MY HOME THAT MAY ACCEPT REMINDER CALLS: _____

- *Please call your insurance co. to see if authorization is needed prior to your first visit with our office.*
- *If a service is provided without authorization and one is needed, you will be responsible for payment.*
- *Many ins. policies limit the number of mental health sessions, types of services and diagnoses they cover.*
- *It is your responsibility to monitor payment by insurance to ensure timely reimbursement to New Growth.*

A copy of the front and back of your insurance card is required. The business office will be happy to make a copy if one is not provided.

Name of Insurance Co. _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Subscriber's Insurance ID Number _____ Group Number _____

Subscriber's Employer _____

Client's relationship to Subscriber: self spouse other