Connection Counseling Center

5710 St. Joseph Ave.
Stevensville, MI 49127
Cell (269) 921-6953
Fax (269) 588-3047

Registration Information

Client Name: ____ Date of Birth: ____________

Address:____

City: ___________________________________ State: _________________ Zip Code: ___________

Primary Phone #: ________________________________ Other Phone #: _______________________

Email Address: ___________________________________

Occupation/Employer/School: ____

Do you have medical insurance? Yes _______ No ______

Name of Primary Insurer: _____________________________ (provide card to copy)

Subscriber Name (if not client): _______________________________________ DOB: ____________

Address of Subscriber (if not client): ____

City: _________________________________ State: _________________ Zip Code: _____________

Referral Source:

____

Emergency Contact Name:____________________________________ Phone #_________________

Current Medications:

____

Financial Responsibility Consent:

I, the undersigned, have read and agreed to the Connection Counseling Center fee policy. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize Connection Counseling Center to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that I am responsible for any costs incurred in the event of collection for outstanding charges over 30 days.

Signature: ____ Date: ___________