Center for Conscious Counseling

Dr. Ralph Whetstine, Psy.D. & Associates, P.C. PH: 312-948-9455
Dawn Whetstine, LCSW PH: 708-825-6037

CLIENT REGISTRATION INFORMATION

First Name_____ Last Name_____
Parent Name if different than above _____
Street Address _____
City, State, Zip _____
Birth Date _____ Age _____ SS# _____
Employer/School _____
Home Phone _____ Work Phone _____
Cell Phone _____How late can calls be returned? _____
Email _____
Referred By _____
Employment Status: □ Employed □ Full-time □ Part-time □ Student
Marital Status: □ Single □ Married □ Other
Emergency Contact: *(name & phone number)* _____

INSURANCE INFORMATION

Insurance Company _____
ID# _____
Group/Policy # _____
Insurance Phone # _____
Policyholder's First Name _____Last Name _____
Street Address _____
City, State, Zip _____
Birth Date _____ Age _____ SS# _____
Patient Relationship to the insured: □ Self □ Spouse □ Child □ Other
Employer _____
Home Phone _____ Work Phone _____

Copay or Coinsurance Amount (may be different than your medical amount) _____
Deductible (may be separate from your medical deductible) _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign, transfer, and set over to Dr. Whetstine all of my rights to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments made by my Insurance Company.

X _____ X _____
Signature of Responsible Party Date

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