

# Approaching Authenticity, PLLC

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## Client Registration

Name \_\_\_\_\_ DOB \_\_\_\_\_

Preferred Name \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Cite, State, Zip \_\_\_\_\_ Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Social Security # \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_

ID Number \_\_\_\_\_ Group # \_\_\_\_\_

Insured Name if other than self \_\_\_\_\_

Insured DOB/SSN/Employer \_\_\_\_\_

Relationship Status \_\_\_\_\_ Significant Other Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Medications/Doctor \_\_\_\_\_

Person who referred you \_\_\_\_\_ May I thank them? \_\_\_\_\_

Medical History (surgeries, major illness, etc) \_\_\_\_\_

Reason for seeking counseling \_\_\_\_\_

I hereby authorize payment of benefits from my insurance provider directly to Approaching Authenticity, PLLC dba Regina A. BlackWolf, MSW, as provider of outpatient mental health services. I understand that I am financially responsible for any amounts not payable/reimbursed by insurance. Additionally, I understand that I will be billed for missed appointments if I am unable to give at least 48 hours notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_