Regina A. BlackWolf, LICSW, MAC
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Client Registration

Name ____DOB ______________________

Preferred Name____________________________________Gender___________Pronouns _____________

Address____ Email________________________________

Cite, State, Zip____Phone ___________________

Employer: ____

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)____

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Reason for seeking counseling____

____

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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______________________