**REGISTRATION**

DATE _____

Mary V Richey, M.S.
MFT #39173, CEAP
707-332-0992

## CLIENT INFORMATION

Name _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Telephone Cell _____ Home _____ Work _____

Sex ☐ M ☐ F Age _____ Birthdate _____ Single ☐ Married ☐ Separated ☐ Divorced ☐ Child ☐

Employed by _____ Occupation _____

Education (Please indicate highest grade completed, or degree) _____

Responsible Party Name _____ Birthdate _____

Business Name/Address _____ Bus. Phone _____

Occupation _____ Social Security # _____

Spouse Social Security # _____

Other Household Members (Include Name, Relationship, Birthdate

_____

_____

_____

_____

## INSURANCE INFORMATION

Insured Name _____ Subscriber ID# _____

Insurance Company _____ Group # _____

EAP Company _____ Authorization # _____ # Sessions _____

## EMERGENCY CONTACT

Name _____ Day Phone _____ Relationship _____

## RELEASE AND ASSIGNMENT

The information I have given is correct to the best of my knowledge. I understand that it will be held in strictest confidence and it is my responsibility to inform this office of any changes in my or my family's medical status. I assign directly to Mary V. Richey all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mary V Richey to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian _____ Date _____