HopeAllianz Inc • 4205 Lancaster Lane North Suite 111 • Plymouth MN 55441 • 763 546 6624

Registration – Client Information

Date_____ **DX Code**_____

Client Information

Client Name (Print)_____ **Date of Birth** _____Age _____

Street Address_____ Home Phone _____

City_____State_____ZIP_____ Mobile Phone _____

Email Address: _____ Work Phone _____

Soc. Sec. #_____Emergency Contact_____ Emerg Phone _____

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Ethnicity ☐ African American ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Jewish ☐ European American (Caucasian)
☐ Hispanic/Latin ☐ Other _____ Religious Affiliation _____

I want to sign up for the portal: YES NO

How do you want to receive your appointment reminders? ☐ E-mail ☐ Text to Mobile Phone ☐ Voice Message to Home or Mobile (circle one)

Employer _____ Occupation_____

Referred by _____May we acknowledge this referral? YES NO

Billing Information

Relationship to client: SELF SPOUSE PARENT OTHER _____

Responsible Billing Party_____Phone _____

Billing Address_____City_____State_____Zip_____

Billing Phone _____

Credit Card on File: VISA MASTERCARD DISCOVER AMERICAN EXPRESS ☐ Private Pay ☐ Deductible ☐ CoPay

Card #_____ Expiration Date _____ CCV _____

I understand that I am ultimately responsible for payment to HopeAllianz Inc for any and all services rendered due at the time of visit. I understand that my credit card on file will be automatically charged following my session. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

_____ _____ _____
Signature Relationship to Client Date

☐ *Private Pay – Fee for Service*

☐ *Employee Assistant Program*

EAP Program_____Phone _____

Claims Address_____City_____State_____Zip_____

Authorization # _____

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____Relationship _____

Address_____City_____State_____Zip_____Date of Birth_____

Soc. Sec#_____Employer_____

☐ *Primary Insurance*

Relationship to client: SELF SPOUSE PARENT OTHER _____

Primary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____Group/Plan #_____

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____Relationship _____

Address_____City_____State_____Zip_____Date of Birth_____

Soc. Sec#_____Employer_____

☐ *Secondary Insurance*

Relationship to client: SELF SPOUSE PARENT OTHER _____

Primary Insurance Company_____Phone _____

Ins Claims Address_____City_____State_____Zip_____

Policy/ID #_____Group/Plan #_____

Policy Holder Information: (if the client is not the employee/policy holder)

Name_____Relationship _____

Address_____City_____State_____Zip_____Date of Birth_____

Soc. Sec#_____Employer_____

Assignment and Release

I authorize HopeAllianz Inc to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to HopeAllianz Inc. I understand that I am responsible for payment for services rendered by HopeAllianz Inc. regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company, I agree to notify HopeAllianz Inc of any changes to my insurance coverage.

_____ _____ _____

Signature Relationship to Client Date