Spectrum Psychological Associates of Washington®

Client Registration Form

(Please Print)

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

_____ Preferred Phone: _____

Client's relationship to person responsible for payment: ☐Self ☐Spouse/Partner ☐Child ☐Dependent

Marital/Partner Status: ☐Single ☐Married ☐Partnered ☐Widowed ☐Separated ☐ Divorced

Sex: _____ Social Security Number: _____ Date of Birth: _____

Referred to this office by: _____

Client's Employer: _____Occupation: _____

Employer's Address: _____

Spouse/Partner's Employer: _____Occupation: _____

Spouse/Partner's Employer's Address: _____

Person Responsible for Payment (If not the client)

Name: _____Date of Birth: _____

Address: _____Home Phone: _____

_____Work Phone: _____

Employer:_____Occupation: _____

Employer's Address:_____

Insurance Information

Insurance Company: _____

Subscriber's Name: _____

Group#: _____

ID#: _____

Client's Relationship to Subscriber:

☐Self ☐Spouse ☐Child ☐Dependent ☐Partner

Subscriber's Employer: _____

Other Insurance: _____

Subscriber's Name: _____

Group#: _____

ID#:_____

Client's Relationship to Subscriber:

☐Self ☐Spouse ☐Child ☐Dependent ☐Partner

Subscriber's Employer: _____

Emergency Contact: _____ Work Phone: _____ Home Phone: _____

Primary Care Physician: _____ Phone: _____

I understand that I am responsible for all fees at the time of service and I am financially responsible for any balance due. I also authorize Spectrum Psychotherapy & Assessment of Snohomish County to release any information requested by my insurance provider for processing of any claims I may file with them and assign payment by my insurance carrier to Spectrum Psychotherapy & Assessment of Snohomish County or Bill Heusler, PsyD, LLC.

Signed: _____**Date:** _____