DHA DAVID HOY & ASSOCIATES
Therapeutic Counseling | Change Your Mind

**Client Registration Form** Date: _______________

Client Name:_____________________________________________________ Date of Birth: ______________

Address:
__________________________________________________________________________________

Phone: (H)_______________________ (C)_________________________ (W)___________________________

Emergency Contact Name:________________________________ Phone Number:_______________________
Employer:______________________________________
Occupation:_________________________________

Psychiatrist Name: _________________________________ Phone Number: ___________________________

**Insurance Information**
Primary Insurance Company:
__________________________________________________________________

Policy/ID Number: _________________________________ Group/Plan #______________________________

Policy Holder (if different than client) Name: ___________________________ Date of Birth: ______________

Address: ___________________________________________________________________________________

Phone Number: _________________________________ Relationship to Client :_________________________

Secondary Insurance Company:
_________________________________________________________________

Policy/ID Number: __________________________________ Group/Plan #_____________________________

Policy Holder (if different than client) Name: _____________________________ Date of Birth: ____________

Address: ___________________________________________________________________________________

Phone Number: _________________________________ Relationship to Client: _________________________

**Responsible Party** (Where should the client's portion of the bill be sent, if not the client?)
Name: _____________________________ Relationship: ________________________________________

Address: ___________________________________________ Phone: _____________________________

My signature below authorizes David Hoy & Associates to bill and release all necessary information to the insurance company noted above. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

________________________________________ __________________________________ ______________

Responsible Party Signature

Relationship

Date