

# Johns Creek Psychology

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## Client Information and Registration

Please read and complete this form. Thank you.

Today's Date \_\_\_\_\_

Client's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male/Female  
(Last) (First) (M.I.)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number(s): Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell/Pager (\_\_\_\_) \_\_\_\_\_

Do we have permission to contact you at any of the above numbers? Yes \_\_\_ No \_\_\_ If no, explain: \_\_\_\_\_

Employer/School \_\_\_\_\_ Social Security Number \_\_\_\_\_

Marital Status: Married/Partnered/Single/Sep/Widow

### Please complete the below information if the client is a minor

#### Mother's/Guardian's Name

Address (if different from client's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number(s): Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell/Pager (\_\_\_\_) \_\_\_\_\_

Do we have permission to contact you at any of the above numbers? Yes \_\_\_ No \_\_\_

Marital Status: Married/Partnered/Single/Sep/Widow/Divorce

Social Security Number \_\_\_\_\_ Employed: Full Time/Part Time/ NA \_\_\_\_\_ Employer \_\_\_\_\_

Father's Name \_\_\_\_\_

Address (if different from client's) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number(s): Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell/Pager (\_\_\_\_) \_\_\_\_\_

Do we have permission to contact you at any of the above numbers? Yes \_\_\_ No \_\_\_

Marital Status: Married/Partnered/Single/Sep/Widow/Divorce

Social Security Number \_\_\_\_\_ Employed: Full Time/Part Time/ NA \_\_\_\_\_ Employer \_\_\_\_\_

If Parents live at separate addresses, which address do we use for statements? Mother \_\_\_ Father \_\_\_

Who is the custodial parent for child? Mother \_\_\_ Father \_\_\_ Joint \_\_\_

If you were referred by a doctor/agency may we thank them for the referral? Y/N Referral Name \_\_\_\_\_

### Emergency Contact Information (to notify in case of emergency)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone number(s): Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell/Pager (\_\_\_\_) \_\_\_\_\_

Address (if different from client's) \_\_\_\_\_

**Insurance Information** (please provide insurance card)

**Policy holder's name** \_\_\_\_\_ Relationship to client: Self/Spouse/Parent/Other

Address of insured person: Same as client's \_\_\_\_\_ client's mother \_\_\_\_\_ client's father \_\_\_\_\_

**Policy holder's social security number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ Gender: M/F

Name of employer (or group) insurance is supplied through \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group/Plan# \_\_\_\_\_

Co-pay \$ \_\_\_\_\_ Deductible? Yes \_\_\_ No \_\_\_ Amount \$ \_\_\_\_\_

Authorization Required? Yes \_\_\_ No \_\_\_ Authorization # \_\_\_\_\_

Number of Sessions Authorized \_\_\_\_\_ Maximum Number of Sessions Allowed Per Year \_\_\_\_\_

Phone number to verify benefits (\_\_\_\_) \_\_\_\_\_

Is the client covered under a secondary insurance policy? Yes \_\_\_ No \_\_\_ If yes, please see the applicable paragraph under the Insurance Reimbursement section in the following agreement.