1611 County Road B, Suite 204
Roseville, MN 55113
Office: 651-340-4597
Fax: 651-493-1105
www.mncoupletherapycenter.com

Client Registration

General Information

Client name: ________________________________DOB: ________Age: ______Today's Date:__________

Gender: Male Female Gender Non-Conforming I'd rather not say

Name of Spouse or Partner: ____

If under 16, please give parent(s) name(s): ____

Marital Status: Single Married Divorced Widowed Other____________________________________

Employment Status: Student Employed Unemployed Retired Other_____________________________

If student, are you Full Time or Part Time? Full Part School attending: ____________________________

If working, please give Occupation and Place of Employment: _____________________________________

Emergency Contact:____Relationship:______________

Emergency Contact Phone #:____________________________Alternative Phone #:___________________

If person filling out form is not client, check here: ☐ Relationship to client? _____________________________

Address and Contact Information

Home Address: ____

City:________________________________State:_______________ Zip Code: ______________________

If you have any special instructions regarding how you would like mailed communications to be handled to ensure your confidentiality, please detail here: ____
____

Home phone #: _____________________________Okay to call? Y N Okay to leave message? Y N

Mobile phone #: ____________________________Okay to call? Y N Okay to leave message? Y N

Work phone #: _____________________________Okay to call? Y N Okay to leave message? Y N

Email: ____Okay to email? Y N

Any special instructions when calling, leaving messages or emailing? __________________________________
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Insurance Information

Insurance Carrier: ______________________________Policy ID #: ____________Group #_____________

Policy Holder Name: _____________________________ Policy Holder DOB: __________ SSN: ___________

I hereby authorize my provider at MN Couple Therapy Center to furnish the above-named insurance company all information they may request concerning my present diagnosis and treatment. I hereby assign to my provider the insurance proceeds to be credited against the total fee for service due on my account. I understand and agree that I am financially responsible for all charges whether or not they are covered by insurance.

Client Signature: ____ Date:_________________________