GREENWOODS
COUNSELING REFERRALS, INC.

Client Registration Form

Referral Source_____ or How did you find out about Greenwoods?_____

Name: _____ Date:_____

Address: _____

Home Phone: _____ Work Phone/Other:_____ Cell: _____

D.O.B.___/____/_____ Gender: F ___ M ___ Marital Status:_____

Number of family members in household and ages:_____

If requesting subsidy please provide annual household income: $_____

I authorize Greenwoods to place a call to the referring physician to discuss the outcome of my visit.

Client Signature: _____***Date***_____

If you do not want to use your insurance, please check here: ☐

Please provide us with your insurance card at the time of your visit. Thank you.

Insurance Information

Name of Company: _____

Insured Name (if other than self) _____D.O.B.___/___/___ Phone: _____

Insurance I.D./Member #_____ Group# _____

I authorize Greenwoods' staff to release the Intake Evaluation and to provide other required information to my insurer and/or its managed care contractor as may be necessary for the administration and provision of my health care coverage. I understand this consent shall remain in effect for one year. I also understand that I may revoke this authorization at any time by written notice to the Greenwoods.

Client Signature: _____ ***Date:*** _____