

HERON RIDGE ASSOCIATES  
REGISTRATION INFORMATION

\*\*\*COPAYS EXPECTED AT TIME OF SESSION. MAKE CHECKS PAYABLE TO: HERON RIDGE ASSOCIATES\*\*\*

**Client Information:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
*Street City/State Zip Code*

Home Phone: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_ Birthdate: \_\_\_\_\_

(Please Circle) Marital Status: S/M/D/W Sex: Male/Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

**Insurance Information:** Please provide insurance card and driver's license for therapist to copy. **I understand it is my Responsibility to check and verify my own insurance benefits.** The Staff of Heron Ridge Associates does not do this for me.

Primary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Group#: \_\_\_\_\_ Service Code: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Employed By: \_\_\_\_\_ Subscribers Birthday: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_ Contract #: \_\_\_\_\_

Co-Pay Requirements: \_\_\_\_\_ Deductible: ( ) None ( ) Yes, amount \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Group#: \_\_\_\_\_ Service Code: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Employed By: \_\_\_\_\_ Subscribers Birthday: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_ Contract #: \_\_\_\_\_

Co-Pay Requirements: \_\_\_\_\_ Deductible: ( ) None ( ) Yes, amount \_\_\_\_\_

( ) Co-Pay ( ) Deductible ( ) Co-Pay/Deductible ( ) Other Amount \_\_\_\_\_

( ) Master Card ( ) Visa Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

**Assignment and Release:**

I, the undersigned, certify that I (or my dependent) have insurance coverage through \_\_\_\_\_  
And assign directly to Heron Ridge Associates or my independent therapist \_\_\_\_\_ all insurance benefits, if any,  
otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by  
insurance. I do hereby authorize them to release all information necessary to secure payment of appropriate benefits. I authorize the  
use of this signature on all insurance submissions, and or credit card charges as applied.

\_\_\_\_\_  
*Responsible Party Signature Relationship to Client Date Signed*

\*\*\*\*\*Office Use Only\*\*\*\*\*

Case #: \_\_\_\_\_ Location Services: \_\_\_\_\_ Therapist: \_\_\_\_\_ DX: \_\_\_\_\_

Authorization #: \_\_\_\_\_ Visits #: \_\_\_\_\_ Dates, From: \_\_\_\_\_ To: \_\_\_\_\_

Insurance Contact for Authorization Name: \_\_\_\_\_ Time/Date of Contact: \_\_\_\_\_