Nicole T. Shiraev, LICSW, PLLC, Psychotherapist in Private Practice
150 Nickerson Street, Suite 105, Seattle, WA 98109
Phone: (206) 496-2426 Fax: (206) 327-9169

Client Registration Form

Demographic Information

Client Name: ____

Client Date of Birth: ___________ Current Age: ____________________

Parent/Guardian's Name:____

Client Mailing Address: ____

Client Street Address (if different from above): _________________________________

____

Preferred Telephone Number: _________________ Detailed Message OK: Y N

Alternative Telephone Number: ________________ Detailed Message OK: Y N

E-Mail Address (optional): ___________________________
*If preferred, to be used for scheduling/appointing matters only.

Emergency Contact Information

Emergency Contact Name: ____

Relationship to Client: ____

Emergency Contact Phone Number(s): ___________________________________

Emergency Contact Address: ____

Current Treatment Provider

Primary Care Physician Name: _______________________________________

Primary Practice or Health-Care Provider System Name: _______________________

Primary Care Provider's Complete Mailing Address:

____

Primary Care Provider's Telephone Number: ____________________________________

Psychiatrist, Other Current Behavioral Health Care Provider, Other Care Provider/Organization:

Name: _________________________ Phone Number: ___________________

Address: ____

Name: _________________________ Phone Number: ___________________

Address: ____

<u>Financial Responsibility</u>

If someone, other than yourself as the patient, is financially responsible, a signed written consent from you is required allowing me to communicate with responsible party about billing/financial matters associated with your care.

Person Responsible for Payment: Self_______ Other ________

Name: _______________________________ Relationship to Patient: _____________

Mailing Address: ____

Telephone Number for Responsible Party: _____________________________________

<u>Insurance Information</u>

Insurance Company: ____

Subscriber Name: ____________________ Subscriber Date of Birth: _____________

Subscriber's Employer: ____

Group #:___________________________ Policy #: ________________________

Unless I pay in full at time of service, I authorize release of information to my Insurance Carriers and its intermediaries, and payment entities regarding the services provided.

Unless payment has already been made in full, I consent to reimbursement being assigned to Nicole T. Shiraev, LICSW, PLLC for services rendered.

I authorize use of my provided Emergency Contact information in situations that my provider deems to be in my best interest in accordance with community clinical standards.

Patient Name (Printed): ____

Patient Signature: ________________________________ Date: ____________

Patient's Parent/Legal Guardian (Printed): _________________________________

Relationship to Patient: ____

Parent/Guardian (Signature):_________________________ Date: ____________