Aspen Psychological Services
640 3 Mile Rd, NW, Suite 101
Grand Rapids, MI 49544
616-785-8900 (office)
616-785-8949 (fax)

Therapist assigned: _____

ASPEN PSYCHOLOGICAL SERVICES
NEW PATIENT REGISTRATION FORM

Date: ___ /___ /___

Client Name: _____
Last First MI

Parent's Name (if client is a minor): _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Phone: _____ (home) ___ Ok to Call ___ Ok to leave message
_____ (cell) ___ Ok to Call ___ Ok to leave message
_____ (work) ___ Ok to Call ___ Ok to leave message

Sex: M or F Date of Birth: _____

Referred by: _____

INSURANCE INFORMATION

Insurance Company: _____
Policy Holder's Name: _____
Claims Address and Phone #: _____
Policy Holder's SSN#: _____ Policy#: _____ Group#: _____
Policy Holder's Date of Birth: _____ Child's relationship to policy holder: _____
Subscriber's Employer: _____

Is this coverage Primary or Secondary (circle one)

Insurance Company: _____
Policy Holder's Name: _____
Claims Address and Phone #: _____
Policy Holder's SSN#: _____ Policy#: _____ Group#: _____
Policy Holder's Date of Birth: _____ Child's relationship to policy holder: _____

Is this coverage Primary or Secondary (circle one)

Authorization:
I authorize any holder of medical information about me to be released to any insurance carrier for the purpose of reimbursement. I authorize benefit payment to go directly to my therapist.

Signed: _____ Date: _____