Paige A. Bender, Licensed Professional Counselor
777 NE 7th Street
Grants Pass, OR 97526
541-660-0080

Client Registration

Name_____ Date of Birth_____

Mailing Address_____

Phone_____ Alternate Phone_____

Email_____ OK to TEXT cellphone re: appointments?_____

Primary Insurance Company_____ Phone _____

Name of Insured_____ Date of Birth_____

Insured ID#_____ Group/member # _____

Secondary Insurance Company_____ Phone_____

Name of Insured_____ Date of Birth_____

Insured ID#_____Group/member#_____

Employer Name_____

Address_____ Phone_____

Primary Care Physician_____

Relevant Medical
Issues/Conditions_____

Current Medications_____

I, the undersigned, have insurance coverage as noted above. I assign directly to Paige Bender, LPC all medical/mental health benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I authorize Paige Bender, LPC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Client/Guardian/Parent/Insured Date