

# RENEE SCHROEDER MS LPC

(Please Print)

## PATIENT REGISTRATION SHEET

Today's Date:		<b>DX CODE:</b>
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### PATIENT INFORMATION

Last Name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Street Address:	City:	State:	ZIP Code:
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Home phone no.: OK to contact? ( )	Cell phone no.: OK to contact? ( )		Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Employer:	Occupation:	Work phone no.: ( )
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Street Address:	City:	State:	ZIP Code:
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Referring Doctor (if required by insurance):	
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Notify Primary Care Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Primary Care Physician	Contact no.: ( )
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### IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone no.: ( )	Cell phone no.: ( )
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### INSURANCE INFORMATION

Insured's Last Name (if different):	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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Home phone no.: (if different) ( )	Cell/Other contact no.: ( )		Birth Date: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )
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Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
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### SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )
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Policy no.:	Group no.:	Relationship to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Renee Schroeder, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

**\* PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**