THE CENTER FOR INTERNET AND TECHNOLOGY ADDICTION
PLUG BACK INTO LIFE!©

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REGISTRATION FORM

Patient Name: _____ Date: _____

Spouse/Partner's Name: _____

Parent(s)' Name: _____

Address: _____

Town: _____ State: _____ Zip _____

Phone Home: _____ Work: _____ Cell: _____

Email Address: _____ (confidential)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ SS#: _____

Place of Employment: _____

Address: _____ _____ _____ _____
Street Town State Zip

Primary Care Physician _____ Phone: _____

Address: _____ _____ _____ _____
Street Town State Zip

Insurance Information:

Insurance Carrier: _____ Phone: _____

Name of Employee _____ ID# _____

Employer: _____ Group # _____

Person to contact in case of emergency

Name: _____ Relationship: _____

Phone # Work: _____ Home: _____

How did you hear about our practice? _____

I hereby authorize the doctor/therapist to release all information about me required to get authorization for treatment visits and to process insurance claims. I further authorize payment directly to The Healing Center, LLC of benefits due me for services rendered. I understand I am financially responsible for charges not covered by insurance (in accordance with my benefit plan), including any applicable deductibles or co-payments. I further understand I am responsible for fees for broken appointments or cancellations without 24 hours' notice.

Can you please circle how you heard of our services? Internet Search Referral Other (describe) _____

_____ _____
Patient's or Authorized Person's Signature Date

**********OFFICE USE ONLY**********

Referred by: _____ Doctor/Therapist _____

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