

# La Perla Counseling & Trauma Response Services, Inc.

Sonja Rudie, M.A., LMHC, C-EMDR, CSAT

1611 - 116<sup>th</sup> Avenue N.E., Suite 221

Bellevue, WA 98004

(425) 739-9483

## CLIENT REGISTRATION FORM

(PLEASE PRINT)

CLIENT \_\_\_\_\_

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Mr. \_\_\_\_ Mrs.  
\_\_\_\_ Miss \_\_\_\_ Ms.

Address \_\_\_\_\_

Home phone: # ( ) \_\_\_\_\_

Work phone: # ( ) \_\_\_\_\_

Cell phone: # ( ) \_\_\_\_\_

\_\_\_\_\_  
City State Zip

Client's relationship to person responsible for bill: \_\_\_ self \_\_\_ spouse \_\_\_ child \_\_\_ dependent Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Marital Status: \_\_\_ single \_\_\_ married \_\_\_ separated \_\_\_ divorced (If married) Spouse's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Client's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date hired \_\_\_/\_\_\_/\_\_\_

Referred to this office by: \_\_\_\_\_

## PERSON RESPONSIBLE FOR BILL, IF NOT CLIENT

Name: \_\_\_\_\_

Home phone: # ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Work phone: # ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell phone: # ( ) \_\_\_\_\_

### PLEASE NOTE:

**Claims submitted to Insurance are subject to individual plan provisions and are not a guarantee of payment.**

**PRIOR TO CLAIMS BEING PAID - YOUR INSURANCE POLICY**

**MAY REQUIRE ONE OR MORE OF THE FOLLOWING FROM YOU:**

- OBTAIN PREAUTHORIZATION PRIOR TO YOUR FIRST APPOINTMENT

- SEE A CONTRACTED PLAN PROVIDER

- A WRITTEN REFERRAL THROUGH YOUR PRIMARY CARE PHYSICIAN

\*\* The provider is not responsible for any unpaid claims; please check with your Insurance Company to receive full benefits.

\*\* A 7-day notice is required for cancellations of appointments. The established fee will be charged for an appointment which is missed or where notification is not received 7 days in advance of the designated appointment time. Last minute sick calls (less than the 7-day notice of cancellation) will be billed at half-rate as a courtesy.

**IN CASE OF EMERGENCY (local friend or relative to be notified; not living at same address):**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**I understand that I am responsible for my total fees at the time of service and I may seek insurance coverage with this provider on my own.**

**SIGNED:** \_\_\_\_\_

**DATE:** \_\_\_\_\_