Pamela L. Gleisser, LISW0S, MSSA
Client Registration

____________________________ __________________________ ____ ____ _____________
Last Name (please Print) First Name MI M/F Date of Birth

_____________________________________ ______________________ ____________ _____________
Street Address City State Zip Code

_______________________________________ __________________ ____________ _____________
Alternate Address for mailing (optional) City State Zip Code

( )________________________________ ( )___________________________ _________
Cell Phone Work Phone Ext.

( )________________________________ ______-_____-___________ ______________
Home Phone Social Security Number Marital Status

_______________________________________ ____
Email Address Spouse/Significant Other Name

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How May We Contact You Regarding Your Care With Our Office?

- **May we text you appointment times? yes___ no ____**
- **May we leave a message at your home with other residents? yes___ no___**
- **May we leave a message on your home answering machine? yes___ no___**
- **May we contact you at your work phone number? yes___ no___**
- **Who may we talk to about your counseling concerns?**
  Name______________________________
  Relationship_________________________
  Phone ( )_________________________ or ( )______________________

- **Is this contact only for emergency purpose? yes, ____ or No ____, you can contact this person on a regular basis.**

Identification of Health Care Providers involved with my care whom I authorize ongoing release of information for continuity of care: (Your Primary Care Physician)

Provider Name____
Phone Number____
Address____
City, State, Zip_______________________________ Type of Provider________________________________

Policy Holder for Primary Insurance Plan__________________________ _______________________
Last Name First Name

_________-_________-__________ ________________________________ ________________________
Social Security Number Relationship to Client Date of Birth

Primary Insurance Company _______________________________________ Co-Payments $____________
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-If your insurance company requires a referral, have you obtained one? ___ ____ ___
N/A Yes
No
-If your visits need pre-authorization, do you have the necessary papers? ___ ____ ___
N/A Yes No

Policy Holder for Secondary Insurance Plan _____ _____
Last Name First Name
_____-_____-_____ _____ _____
Social Security Number Relationship to Client Date of Birth
Secondary Insurance Company_____
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I Hereby give my consent to Pamela L.Gleisser,LISW-S MSSA, to use and disclose my protected health information for the purpose of treatment , payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize Pamela L Gleisser,LISW-S MSSA to provide counseling for me, or to this patient whom I am a legal guardian. This care may include services related to my, or the identified person's health and, may include preventative, diagnostic, therapeutic, assessment or review of mental status/function. This consent includes contact and discussion with other health care professionals for care and treatment.
Consent for release of information for payment and for operations: I, also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice notice.
Consent related to the Privacy Notice: I have had the opportunity to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice or in writing. I understand I have the right to request how my protected health information has been disclosed, but this practice is not required to agree with my restrictions.

Patient /Guardian Signature_____ Date_____
Consent for the Assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be my responsibility by my contract with my insurance plan. I further understand that my insurance may not cover some services. It is my responsibility to obtain information from my health plan about service coverage.
Patient/ Guardian Signature_____ Date_____

Print Name_____