Royanne Ukestad, MFT
18181 Butterfield Boulevard, Suite 105
Morgan Hill, CA 95037
408-776-1009

Client Registration Form Date:____________________

PATIENT INFORMATION

Name:________________________________ Soc. Sec. #________________________

Address:______________________________ Marital Status__________ Sex: M F

City:______________________ State:__________ Zip: ________ Birth date:__________

Home Phone (____)______________ Bus # (___)______________ Msg # (___)________________

Employed By:______________________________ Occupation________________________

Business Address:___________________________ City/State/Zip______________________

RESPONSIBLE PARTY INFORMATION

Name:________________________________ Soc. Sec. #________________________

Address:______________________________ Marital Status__________ Sex: M F

City:______________________ State:__________ Zip: ________ Birth date:__________

Home Phone (____)______________ Bus # (___)______________ Msg # (___)________________

Employed By:______________________________ Occupation________________________

Business Address:___________________________ City/State/Zip______________________

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION FOR EACH PLAN UNDER WHICH THE PATIENT IS COVERED

	INS. #1	INS. #2
INS CO. NAME	______________________	______________________
INSURED'S NAME	______________________	______________________
INSURED'S SOC. SEC. #	______________________	______________________
GROUP NAME/#	______________________	______________________
PLAN EFFECTIVE DATE	______________________	______________________
INSURED'S DATE OF BIRTH	______________________	______________________

How did you hear about my office?____

What are the benefits you wish to achieve from counseling?____

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I, the undersigned, assign insurance benefits directly to Royanne Ukestad, MFT, if any, otherwise payable to me for services rendered. I hereby consent to the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am responsible for all charges incurred for patient regardless of insurance coverage. I understand and agree that all accounts are due and payable at the time service and that insurance is being billed as a courtesy. In insurance assigned cases, Royanne Ukestad, MFT agrees to accept the charge determination of the insurance carrier as the full charge and the patient is only responsible for the deductible, co-insurance, and non-covered services. My insurance carrier may only pay for services that it determines "reasonable and necessary". If my insurance carrier denies payment for these services, I agree to be personally responsible for the payment.

I understand that appointments canceled with less than 24 hour notice may be billed for the time reserved.

As my therapist, I understand that Royanne Ukestad, MFT is bound legally and ethically to maintain confidentiality and privileged communications. California law states the following legal exceptions: (1) court subpoena of records; (2) a crime contemplated against someone requires my therapist to notify the potential victim and the police; (3) a threat of injury to self or others, and, (4) suspicion of abuse or neglect of children and elders requires notification to the proper authorities.

Signature of Responsible Party_______________________________

FOR THERAPIST USE ONLY:

Procedure	Code	Charge
Initial Assessment	90801	
Individual Psychotherapy 45-50"	90806	
Individual Psychotherapy 45-50"	90812	
Conjoint Family Psychotherapy	90847	

Diagnosis	Code
dx 1	
dx 2	