

REGISTRATION FORM

JENNIFER NOVELLO, LMSW, ACSW, PLLC

1. Client Information

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **Zip:** _____

Marital Status: Single | Married | Partnered | Separated | Divorced | Widowed

Employer: _____

Whom may we thank for referring you? _____

2. Contact Information

Please list only phone numbers and email where you agree to be contacted by Jennifer Novello.

Home: _____ **Cell:** _____ **Work:** _____

Email: _____

Check all methods of communication you consent to: phone call only voice mail text email

IN CASE OF EMERGENCY, CONTACT

Name: _____ **Relationship:** _____

Home: _____ **Cell:** _____ **Work:** _____

3. Insurance Information (Please present Insurance Card for Photocopy)

Responsible Party for insurance billing? _____

Relationship to client: _____ **Birthdate:** _____ **Phone:** _____

Address/City/State: _____

Insurance Type 1: _____ **Subscriber#:** _____

Group #: _____ Policy Holder Name: _____

Insured DOB: _____ Employer: _____

Insurance Phone #: _____

Insurance Type 2: _____ **Subscriber#:** _____

Group #: _____ Policy Holder Name: _____

Insured DOB: _____ Employer: _____

Insurance Phone #: _____

4. Billing Authorization

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information for paper and electronic billing to your insurance company.

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Jennifer Novello, LMSW, ACSW, PLLC to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Jennifer Novello, LMSW, ACSW, PLLC. If I have Medicare insurance, I authorize Jennifer Novello, LMSW, ACSW, PLLC to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance.

This authorization is valid indefinitely until revoked by myself or by Jennifer Novello, LMSW, ACSW, PLLC by written request.

SIGNATURE: _____ **DATE:** _____