LEGACY CENTER
19751 E. MAINSTREET SUITE 218 - PARKER CO 80138
PHONE: 303-841-4005 - FAX: 720-851-4890
INFO@LEGACYPARKER.COM - WWW.LEGACYPARKER.COM

Family / Couples Registration Form

ADULT INFORMATION

Name: ____ DOB: ______________

Address: ____ City: _________________ Zip: ___________

Home Phone: ________________ Cell Phone: ________________ Work Phone: _________________

Employer: _____________________________ E-mail: _____________________________________

Name: _______________________________________ DOB: ______________

Address: ____ City: _________________ Zip: ___________

Home Phone: ________________ Cell Phone: ________________ Work Phone: _________________

Employer: ______________________________ E-mail: _____________________________________

List all Phone #'s you authorize Legacy to leave you messages: ____

E-mail: ________________________________

I authorize Legacy to send Newsletters and/or program updates via e-mail and/or mail: ____ Yes ____ No

INSURANCE DATA

Insurance Company Name: ________________________________ ID #: ______________________________

Policy Holder Name: _____________________________________ Group #: ___________________________

Policy Holder DOB: ________________ Employer: ____________________________

Policy Holder Social Security #: _____________________ Insurance Phone Number: ____________________

Insurance Address: _________________________ City: _________ State: _____ Zip: _____

REFERRAL INFORMATION

Referral Source____

Briefly describe the reason for the referral: ____
____
____
____
____

CHILDREN'S INFORMATION

Name	DOB	Gender	Specific Concerns, if any

Are there learning or education problems with any of the child's siblings, parents, extended family? Please describe the nature of problems? ____
____

Are there mental health problems with any of the child's siblings, parents, extended family? Describe the nature of problems? ____
____

Are there behavior problems with siblings, parents, extended family? _______________________________
____

Please describe custody arrangements of patient, if applicable. Indicate who has mental health decision power.
____
____

Is there any current DCS (Department of Child Services) involvement: ___________

If yes, DCS Caseworker: ____________________ Briefly describe DCS involvement:__________________
____
____

MEDICAL HISTORY

Family Member	Describe significant illnesses, surgeries, head injuries, and/or allergies

Medication Information

Family Member	Medication	Dosage	Prescribing Physician	Purpose of Medication

FAMILY TREATMENT HISTORY

Family Member	Evaluation/Counseling Provider	Type of Service (e.g., counseling, occupational therapy, physical therapy, speech therapy, etc.)	Dates of Services

List your main counseling and treatment goals for your child and/or family

1. ____

2. ____

3. ____

Which family members need to participate in family sessions?

____
____
____

What will best encourage participation by all members?

____
____
____

Legacy Center Credit Card on File

Date: ____________________

Client's Name: ______________________________________

Client's DOB: _______________________

As a courtesy Legacy Comprehensive Counseling & Consulting will bill your insurance company for their portion of the fee if the therapist you are seeing is in your insurance company's network. Payment of your deductible, co-pay and/or co-insurance is your responsibility and may be collected from you at the time the service is rendered. Some services (including some psychological testing services) may be processed through your insurance company before you are charged for your portion. In these situations, your credit card on file will be charged for your portion (copays, deductible, co-insurance) immediately after Legacy Center receives notice of your amount due from your insurance company. Legacy Center is unable to give an estimation of when your credit card on file will be charged due to the unknown length of time that your insurance company will take to process your claim. If your insurance company denies payment for any reason, the entire fee is your responsibility and will be charged to your credit card on file upon notice of denial from your insurance company. ***WE ACCEPT ALL CARDS EXCEPT AMERICAN EXPRESS***

I, ____________________, authorize the use of my credit card for the following charges: Appointment fees including, but not limited to, co-pays, co-insurances, deductibles, private pay fees, and charges denied by your insurance company, as well as charges related to No-Shows, Late Cancels and Late Fees.

Signature: ______________________________________ Date: ______________________

Authorized Credit Card Information **(Please note that a credit card is required)**

Card Number : _______________ - ________________- ______________ - _______________

Expiration Date : _______ / ______________

Billing Zip Code: ______________________

Card Holders Name: ____

Card Holders Signature: ______________________________________ Date: ___________________

If you would like us to first try to run appointment fees through your HSA or FSA card prior to charging the remaining balance left over to your credit card, please fill out your HSA/FSA card information below (Please note: We will not bill charges related to no-shows, late-cancels or late fees to your HSA/FSA card; these charges will go directly to your credit card on file.)

Authorized HSA/FSA Card Information

Card Number : _______________ - ________________- ______________ - _______________

Expiration Date : _______ / ______________

Billing Zip Code: ______________________

Card Holders Name: ____

Card Holders Signature: ______________________________________ Date: ___________________