KRISTIN HULTGREN, MA, LCPC, CTMH

PATIENT REGISTRATION SHEET

Today's Date:	Provider: Kristin Hultgren	Referred by:

PATIENT INFORMATION

Last Name:	First:	Middle:	Email:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street Address:	City:	State:	ZIP Code:

Home phone no.: ( )	Cell/Other contact no.: ( )	Social Security no.:	Birth Date: / /	Sex: ❑ M ❑ F

Employer:	Occupation:	Work phone no.: ( )

Street Address:	City:	State:	ZIP Code:

Referring Doctor (if required by insurance):	

Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact no.: ( )

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone no.: ( )	Cell phone no.: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home phone no.: **(if different)** ( )	Cell/Other contact no.: ( )	Social Security no.:	Birth Date: / /	Sex: ❑ M ❑ F

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )

Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )

Policy no.:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jennifer Nichols, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

_____ _____

Patient/Guardian signature *Date*

*** PLEASE NOTE: 24 HOUR CANCELLATION POLICY – Please be advised that 24 hours notice is required for cancellations. Otherwise, your account will be charged for the session amount. Thank you for your cooperation.**