LATITUDE THERAPEUTIC PRACTICES
REGISTRATION FORM

(Please Print)

How did you find me?

CLIENT INFORMATION

Last Name:	First name:	Middle:

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):

Date of Birth:	Age:	Gender: ❑ M ❑ F ❑ Other If other, specify:

Home Address:	City:	State

Primary Phone: ( )	Alt Phone: ( )	Best days/times to reach you:
Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

I am a member of many insurance panels and will work with insurance companies to secure your mental health benefits, if you so desire. In addition, many people have out-of-network mental health benefits, which I will also help to access. Please note that you, not your insurance company, are responsible for my fee, so if for some reason your insurance does not cover my fee, you will be responsible to do so.

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:
Primary phone #: ( )	Other phone #: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for all treatment. I also authorize Latitude Therapeutic Practices, LLC to release any information required to process any insurance claims that I may submit.

____ Signature

____________________________ Date