

# Julie Lingler, MSW, LISW REGISTRATION FORM

(Please Print)

Today's date:			How did you find me?			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )	
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: (    )		
Cell Phone no.: (    )	Best days/times to reach you:			Preferred # to reach you:		

## INSURANCE INFORMATION

I am not a member of any insurance panels, however many people have out-of-network mental health benefits, and I am happy to provide my clients with the form needed to obtain reimbursement. If you would like to submit claims to your insurance, to be reimbursed to you, please let me know and I will give you the form with my information completed. Please note that you, not your insurance company, are responsible for my fee, so you will pay me and all reimbursement checks will come to you.

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
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The above information is true to the best of my knowledge. I understand that I am financially responsible for all treatment. I also authorize Julie Lingler, MSW, LISW to release any information required to process any insurance claims that I may submit.

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*Patient/Guardian signature*

\_\_\_\_\_  
*Date*