Terri Ross Family Connections, LLC
Terri Ross LMFT
416 Heritage Place
Faribault, MN 55021

Patient Registration

Client Information

Client Name:____

Address:_____________________________City:_________________State:____Zip:_____________

Home Phone:_________________________________Work Phone:___________________________

Gender:_________Date Of Birth:_____________

Marital Status:_________Employer:____

Insurance

Insurance Company:______________________________________Phone:_____________________

ID#_______________________Policy#__________________________________Group#___________

Policy Holder Information

Insured Person____

Date of Birth:__________Relation to Client:_____________Employer:_____________________________

Secondary Insurance

Insurance Company:______________________________________Phone:_____________________

ID#_______________________Policy#__________________________________Group#___________

I assign all benefits from insurance or other third-party coverage to the provider of service. I understand that by signing this form I acknowledge that if my insurance carrier or HMO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by provider or its independent contractors. A photocopy of this authorization may be honored.

Signature:_________________________________Date:_________________________

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