Wham Counseling, LLC

Patient Registration Form

Patient's Name:_____ Date:_____

Birth Date:_____ SSN:_____ Male:_____ Female:_____

Address:_____

State:_____ Zip code:_____ Phone Contact:_____

Email address: _____

_____

Insurance Information

Name of insurance_____

Policy ID/GROUP #:_____Employer:_____

Policy Holder Name: _____

Policy Holder address (if different from above): _____

Policy Holder DOB: _____ Policy Holder SSN: _____

This document constitutes my permission for Steve Wham, LCSW to contact the above named organization or health insurance carrier regarding health benefits and limitations on my coverage. I hearby instruct and direct the above insurance company to make checks payable and mailed directly to:

Steve Wham, LCSW

201 NW 4TH Street, Suite 108

Evansville, IN 47708

The professional or medical expense benefits allowable and otherwise payable to mu under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____

Signature of Policy Holder Date

Witness