Connection Counseling
SERVICES
Reconnecting Lives, Restoring Futures

CLIENT REGISTRATION FORM

Name: _____ **Home Phone: ( )**_____
(Last) (First) (MI)
Cell Phone: ( )_____

Address: _____ **Work Phone: ( )**_____
(Street or P.O. Box) (Apt. or Rt.)

_____ **Race:** _____
(City) (State) (Zip) (Optional)

Gender: _M ____F DOB: ___/____/_____ SS#: _____/_____/_____

Referral Source:_____

Drivers License Number:_____

Email Address:_____

Employer: _____ **Address:** _____

Spouse's Name: _____ **Employer:** _____ **Phone#:**_____

Who is responsible for payment of services (if different from above)?

Name: _____ **Relation to Client:**_____
(Last) (First) (MI)

Address: _____
(Street or P.O. Box) (Apt. or RT.) (City) (State) (Zip)

Work Phone: ( )_____ **Home Phone: ( )**_____ **SS#**_____

Primary Insurance: _____ **Phone:** _____

Insurance Company's Address: _____

Primary Physician: _____ **Phone:**_____

Insured's Name: _____ **DOB:**_____/_____/_____ **Gender: M or F**

Christopher Merrell, Ed.D., LPC Phone: 469-337-1160/ Fax: 972-218-7754 1106 Sante Fe Trail Suite 3, Duncanville, Texas 75137

Insured's ID# _____ **Group#:** _____

Relationship to Client: _____ **Employer Plan:** _____ **Yes** _____ **No**

Employer: _____

Emergency Contact: _____
(Name) (Relation) (Phone #)

I authorize the release of Private Healthcare Information required, in the course of my services with Christopher Merrell M.A., L.P.C., to process third-party claims for benefits. I also release benefits for above services to be paid directly to Christopher R. Merrell M.A., L.P.C.

_____ _____
Signature of Client or Responsible Party **Date**