Cia Flodin, MEd
Licensed Mental Health Counselor

CLIENT REGISTRATION

Last Name ____ First Name____

Address ____________________________________City ________________________ State _____ Zip Code _____________

Phone: Hm ____________________________ Wk __________________________ Msg/Cell __________________________

Employer _____________________________________ SS# ___________ - _________ - ___________ Male ☐ Female ☐

Marital Status: M☐ S☐ D☐ Other☐ Student☐ F/T☐ P/T☐ Age ____________ DOB _______/_______/________

Name of Spouse/Partner ____________________________ (If minor, name of Guarantor) ______________________________

Address ____ Phone ______________________________

Referred By ____ Therapist requested___________________________________

Has any other family members been seen in our office? No ☐ Yes ☐ (Name) ____

Who may we contact in case of an emergency? Name _______________________________ Phone _____________________

INSURANCE INFORMATION *(We will be happy to bill your insurance if an insurance card is provided.)*

Insurance (*Primary*) ______________________________________ Address ____

City __________________________________ State ________ Zip Code _______________ Phone _____________________

Group Plan # __________________________ Subscriber ID # _____________________ **Subscriber's DOB** ____/____/____

Subscriber's Name ____ Subscriber's SS# ______ - ____ - ________

Relationship to Responsible Party ______________ **Employer** ____

Insurance (*Secondary*) _______________________________________ Address _____________________________________

City __________________________________ State ________ Zip Code _______________ Phone _____________________

Group Plan # __________________________ Subscriber ID # _____________________ **Subscriber's DOB** ____/____/____

Subscriber's Name ____ Subscriber's SS# ______ - ____ - ________

Relationship to Responsible Party ______________ **Employer** ____

FINANCIAL DISCLOSURE

Clients are responsible for determining what their insurance will cover. All co-pays will be made at time of the appointment; if you are unsure of the co-pay amount, you will be charged 50% of the office visit. Clients will be billed for missed appointments if the office is not notified 24 business hours prior to the appointment. Insurance does not cover missed appointment charges. Cia Flodin MEd LMHC will electronically bill primary and secondary insurance providers.

RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to the physician/therapist named on this form. I understand that I am financially responsible for non-covered services. I also authorize the release of any medical information necessary to process claims

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Client / Legally Responsible Person Date

1030 N Center Parkway • Suite 316 • Kennewick • Washington 99336
Ph 509.845.0366 Fax 509.413.0444 email: cia@ciaflodin.com
www.ciaflodin.com