John Eikel, MA, LPC
4330 Adams Rd. ste. 100
Norman, OK 73069

Client Registration

Please fill out the following information form as completely as possible.

Name:____ Date: _________________
Date of Birth: _____________________ Age:_________
Address:______________________________________City: ____________________ State:______ Zip:_________
Home Phone:_______________________Cell:_____________________Email:____________________________
Employer/School:____
Referred by:____

Emergency contact: Name____Phone _________________________

Insurance Information

Primary Policy Holder:

Name______________________________ __________Relationship to client__________________
Address____
Employer_______________________________________ Phone __________________________
Date of Birth:________________________________
Insurance Company______________________________ Phone _______________________
Policy ID#_______________________________________Group#_________________________
Copay $_____

COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE. IF NO INSURANCE INFORMATION IS FURNISHED TOTAL FEE OF $115 IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

24 HOURS CANCELLATION NOTICE IS REQUIRED TO AVOID A FEE OF $55.

I AUTHORIZE PAYMENT OF BENEFITS TO MY THERAPIST. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE OR THIRD PARTY. I HAVE READ AND SIGNED ALL REQUIRED AUTHORIZATIONS AUTHORIZING THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS.

____ _________________________
Signature of Responsible Party Date