

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: _____
Cell Phone: _____ Email: _____
Employer: _____
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 \$140 IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

24 HOURS CANCELLATION NOTICE IS REQUIRED TO AVOID A FEE OF \$75.

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