

BETH BARRINEAU WARD, LCSW
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CLIENT REGISTRATION FORM

Phone: (704) 814-4677

Voice Mail: (704) 844-2358

CLIENT:

Name: _____
Last First Middle Initial

Address: _____
Number & Street Apt. #

_____ City State Zip

Birth Date: ____ / ____ / ____ Age: ____ Sex: M () F () Martial Status: ____ SS#: _____ - ____ - _____

Home Phone: (____) ____ - ____ Work: (____) ____ - ____ Cell: (____) ____ - ____

Referred by: _____ Primary Care Physician: _____

E-Mail Address: _____

If Client is a minor:

School: _____ Grade: _____

Mother: _____ Father: _____

Custody: MOTHER FATHER JOINT OTHER

Legal Guardian (if applicable): _____

Nearest Relative: _____ Relationship to Client: _____

Phone: (____) ____ - ____

PRIMARY INSURED:

Employer: _____ Occupation: _____

Responsible Party (other than client): Client's Relationship: _____

Name: _____
Last First Middle Initial

SS#: _____ - ____ - ____ Sex: M () F () Phone: (____) ____ - ____ Birth Date: ____ / ____ / ____

Address (if different): _____
Number and Street Apt. #

_____ City State Zip

Do you have an insurance authorization #? Y () N () # _____

Are you going to be using secondary or supplemental insurance: Y () N ()

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH _____
INSURANCE COMPANY AND ASSIGN DIRECTLY TO BETH B. WARD, MSW, LCSW, ALL INSURANCE BENEFITS, IF ANY OTHER WISE PAYABLE TO ME
FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR DEDUCTIBLES, COPAYS, AND MISSED APPOINTMENTS
OR APPOINTMENTS NOT CANCELLED WITHIN 24-HOURS. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO
SECURE THE PAYMENT BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

RESPONSIBLE PARTY SIGNATURE: _____

PRINT NAME: _____

RELATIONSHIP: _____ DATE: _____