Lisa B. Kelly, LCSW, LLC
225 N. Notre Dame Ave, Suite 5
South Bend, IN 46617

Lisa B. Kelly, LCSW, LLC

# REGISTRATION FORM

Today's Date: ______________________ Who referred you to my practice? _________________________

**Patient Information**

Last Name:_____________________________ First name: _____________________________

Date of Birth: __________________________ SSN: ___________________________________

Cell phone: ___________________________ Home phone: ___________________________

Address: _________________________________________________________________________

City,State, zip__________________________________________________________________________

Email address: __________________________________________

***I give my consent for a text reminder to be sent to my cell phone 24 hours prior to future appointments:*** (sign here): _______________________________________________________

Insurance provider: ______________________________________________________

Subscriber's name: ______________________________________________________

Subscriber's DOB: _______________________________________________________

Subscriber's Employer: ___________________________________________________

Doctor's name, practice location and phone number: ________________________________________

_______________________________________________________________________________________

Emergency Contact (Name, phone number relationship to you): ___________________________

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***Consent for treatment and fee agreement: I consent to receive services from Lisa B. Kelly, LCSW and I agree to pay for services rendered that are not covered by the above mentioned insurance company. I authorize payments to be paid directly to Lisa B. Kelly, LCSW, LLC. I also understand that I am financially responsible for any balance due on my account. I understand that I will pay all copays and deductible amounts at the time of service. I also authorize Lisa B. Kelly, LCSW, LLC and/ or my insurance company to release any information necessary and/ or required to process my claims.***

(sign here): ___________________________________________________________Date: _____________