

HOOPER COUNSELING AND CONSULTATION SERVICES, LLC  
*Promoting Authenticity in Thinking, Doing, and Being*  
*Connie Bussey-Hooper, LMSW, DCSW, Owner and Mental Health Therapist*

**CLIENT REGISTRATION INFORMATION**

<b>Full Legal Name:</b>	<b>Affirmed Name:</b>	<b>Gender:</b>
<b>Home Address:</b>	<b>City/State/Zip:</b>	<b>Date of Birth:</b>
<b>Preferred contact number:</b>	<b>Secondary Contact Number:</b>	<b>Partnered Status:</b>
Hooper Counseling and Consultation Services, LLC may leave messages on the listed phone above regarding appointments, billing, or other items regarding my care: Y or N	Hooper Counseling and Consultation Services, LLC may leave messages on the listed phone above regarding appointments, billing, or other items regarding my care: Y or N	<b>Email Address:</b>
<b>If Minor, parents or guardian name:</b>	<b>If Minor, Parents or guardian phone:</b>	<b>*If Minor and parents divorced, who is responsible for care? Provide documents of legal custody.</b>

**Who lives in the home with the client?**

Name:	Relationship to you:	Age:

**Payment Responsibility Information:**

<b>Person Responsible for Payment and DOB:</b>	<b>Phone:</b>
<b>Person Responsible for Payment Home Address:</b>	<b>Employer:</b>
<b>Insurance Company:</b>	<b>Phone of back of insurance card:</b>
<b>Name of Policy Holder:</b>	<b>Address on back of Insurance card:</b>
<b>Policy Number:</b>	<b>Group Number:</b>

**Secondary Insurance (If applicable):**

Person Responsible for Payment and DOB:	Phone:
Person Responsible for Payment Home Address:	Employer:
Person Responsible for Payment Home Address:	Phone of back of insurance card:
Insurance Company:	Phone of back of insurance card:
Name of Policy Holder:	Address on back of Insurance card:
Policy Number:	Group Number:

I hereby authorize payment directly to Hooper Counseling and Consultation Services, LLC, of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services on my behalf or on behalf of my dependents. I understand that insurance Explanation of Benefits will be sent to the policy holder and may include service information. I authorize the above providers/supplier of services at Hooper Counseling and Consultation Services, LLC to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to our billing company (Mid-Michigan Medical Management: <http://midmimed.com/> or 517 676-9788 ) for paper & electronic billing and your insurance company. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize this therapist's billing company (Mid- Michigan Medical Management: <http://midmimed.com/> or 517 676-9788 ) to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to therapist. If I have Medicare insurance, I authorize the therapist or billing representative to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by the therapist by written request.

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Signature and printed name of client/parent/guardian

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Date

*Psychological and Behavioral Consultants*  
2535 E. Mount Hope Ave. Lansing, MI 48910-1913  
517-999-0990 Office  
517-204-4670 Cell  
[conniehooper@midmimed.com](mailto:conniehooper@midmimed.com) |