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

Full Legal Name:	**Affirmed Name:**	**Gender:**
Home Address:	**City/State/Zip:**	**Date of Birth:**
Preferred contact number:	**Secondary Contact Number:**	**Partnered Status:**
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**	**Email Address:**
If Minor, parents or guardian name:	**If Minor, Parents or guardian phone:**	***If Minor and parents divorced, who is responsible for care? Provide documents of legal custody.**

Who lives in the home with the client?

Name:	**Relationship to you:**	**Age:**

Payment Responsibility Information:

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

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.

_____ _____

Signature and printed name of client/parent/guardian **Date**

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517-204-4670 Cell
conniehooper@midmimed.com |