Registration Form Chaska Counseling and Guidance, LLC Lisa Knudson, MSW, LICSW

Patient Name Print List Name First Name Initial Home Phone	Patient Information	1				
threet Address	-			Data of Divide		
State ZiP	Last Name Street Address	First Name	Initial	_ Date of Birtil Home Phone		
Emergency Contact		State	ZIP			
ex: Female Male Age						
Primary Insurance Primary Insurance Company	ex: 🗆 Female 🗆 Male Age	Marital Status: ☐ Single ☐ Married	d □ Partnered □ Divorce	d 🗆 Separated	☐ Widowed ☐ Other	
Primary Insurance rimary Insurance Company so Claims Address City State Zip Group/Plan # solicy Holder Information: (if the patient is not the employee/policy holder) ame Last name First Name Last name Employer Secondary Insurance condary Insurance solicy State Zip Date of Birth City State Zip Date of Birth City State Zip Date of Birth City State Zip Group/Plan # Secondary Insurance condary Insurance Company Phone so Collaims Address City State Zip Group/Plan # Secondary Insurance Company Phone Last name First Name Last name First Name Last name Relationship City State Zip Date of Birth City State Zip Date of Birth Assignment and Release the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all in neenfits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby as the healthcare provider listed at the top of this form all in the neenfits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby as the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all in the but here provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all in the but here provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all in the but here provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all in the but here provider to release all information and in the but	mployer	Occupat	tion			
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last name Last name First Name Initial Relationship	olicy/ID #		Group/Plan #			
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Last name First Name Initial ddress	olicy Holder Information: (if the nation) is not	the employee/policy holder)				
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Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?) Assignment and Release Phone	Last name					
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Relationship	oc. Sec#	Employer				
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Assignment and Release the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all in enefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby aure healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insubmissions.	responsible Fully (Vhere should the patient's portion of the	bill be sent, if not to the patie	nt?)		
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Responsible Party Signature Relationship To Patient Date	enefits, if any, otherwise payable to me for serv he healthcare provider to release all information	ices rendered. I understand that I am fina	ancially responsible for all cha	arges whether or n	ot paid by insurance. I hereby author	
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