

**ROY B. NASH, M.Div., L.M.F.T., L.C.P.C.**

**BELIEF-FOCUSED CARE & HEALING 5004 EAGLE RIDGE - SPRINGFIELD, IL 62711-7830 - 217-415-2978**

**CLIENT REGISTRATION INFORMATION**

[ PLEASE: PRINT CLEARLY AND PROVIDE INFORMATION FOR ALL BLANKS.]

**PLEASE PRESENT YOUR INSURANCE CARD(S) - WHERE APPLICABLE - TO THE RECEPTIONIST FOR PHOTOCOPYING IN ORDER TO AVOID PROBLEMS IN PREPARING YOUR INSURANCE CLAIM FORMS. THANK YOU !!!**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ GENDER \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
REFERRAL SOURCE(S) \_\_\_\_\_ EMAIL: \_\_\_\_\_  
EMPLOYED BY (IF STUDENT, NAME OF SCHOOL) \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ X \_\_\_\_\_  
EMPLOYER'S FULL ADDRESS \_\_\_\_\_  
EMPLOYED POSITION \_\_\_\_\_ EMERGENCY PHONE # \_\_\_\_\_

**ACCOUNT INFORMATION [ PLEASE RESPOND TO ALL ITEMS ]**

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ RELATIONSHIP TO CLIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE # \_\_\_\_\_ CELL PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
EMPLOYED BY (IF STUDENT, NAME OF SCHOOL) \_\_\_\_\_ WORK PHONE # \_\_\_\_\_ X \_\_\_\_\_  
EMPLOYER'S FULL ADDRESS \_\_\_\_\_  
EMPLOYED POSITION \_\_\_\_\_ EMERGENCY PHONE # \_\_\_\_\_

I understand that all services provided by Roy B. Nash, L.M.F.T., L.C.P.C., are billable. Some services, such as, school conferences, legal evaluations, custody cases, court testimony, depositions, consultations with persons outside this office, such as, teachers, attorneys, etc., may not be covered by insurance and are my personal financial responsibility, and I acknowledge this obligation for payment. **PLEASE INITIAL [ X ] \_\_\_\_\_**

I authorize release of information necessary to file a claim with my insurance company, and to authorize payment of medical benefits to the provider of services filing my claim. I also authorize Roy B. Nash to assess and treat the client using commonly accepted outpatient procedures. **PLEASE INITIAL [ X ] \_\_\_\_\_**

**Chaplain Roy B. Nash is not bound by orders on a divorce decree. The parent who arranges for and brings the child(ren) to him for assessment and/or treatment will be financially responsible to Chaplain Nash and will be expected to adhere to the office payment policies as outlined below.**

**I have been advised by Roy B. Nash to call and check with my insurance carrier to confirm my applicable coverage for assessment and treatment by Roy B. Nash, and to request pre-certification, if required, prior to any evaluation or treatment.** If my insurance company refuses to pay because I have failed to follow their procedures, the full fee will be my responsibility. If i have the option to be treated without the carrier's authorization and elect to do so, it is understood that the entire fee will be my personal responsibility although Roy B. Nash and/or his bookkeeper files a claim on my behalf. **If I am covered by a managed care company contracted with Roy B. Nash and I have a co-payment to make, I agree to make that co-payment at the time of my visit.** If I am covered by a managed care company which has not contracted with Roy B. Nash as a preferred provider, it is the policy of Roy B. Nash to collect charged fees for services at the time of the visit, although he will files a claim on my behalf for any possible out-of-network reimbursement. **Further, I understand that I may be financially responsible for fees for failed appointments not cancelled in advance by 24 hours.** **PLEASE INITIAL [ X ] \_\_\_\_\_**

**I hereby agree that should my account become delinquent and it has to be referred for collection, I agree to and accept the terms of the Agreement to Pay Collection Fees as stated on Page 2 or the reverse of this form.** This is also true of unpaid checks on your account returned by my bank. **PLEASE INITIAL [ X ] \_\_\_\_\_**

A copy of this signature and the initials is valid as the original.

DATE \_\_\_\_\_ SIGNATURE OF RESPONSIBLE PERSON [ X ] \_\_\_\_\_

SIGNATURE OF CLIENT, EVEN IF NOT THE RESPONSIBLE PERSON

SIGNING ABOVE --[ FOR 12 YEARS OF AGE AND OLDER ] ----- [ X ] \_\_\_\_\_

**AGREEMENT TO PAY PERCENTAGE COLLECTION FEE**

By my signature on Page 1 of the **Client Registration Information** form, I, the Client, agree that, in the event any unpaid balance beyond 120 days, including principal, interest of 20% beyond 120 days and late fees, which are placed with or referred to a collection agency, attorney or other third party service for collection, a fee ranging between **35% – 65%** of the unpaid balance shall be added to the unpaid balance due from Client (the **“authorized percentage collection fee”**).

In addition to the unpaid balance due and the **“authorized percentage collection fee”**, Client **agrees to pay all other costs incident to collection incurred directly or indirectly** by Therapist or by the collection agency, attorney or other third party service, to collect the total amount due from Client under this agreement, which incidental collection cost may include, but are not limited to: court costs, sheriff’s fees, interest and late fees.

Client further agrees that the **“authorized percentage collection fee”** of 35% - 65% and the additional incidental costs of collection reflect the actual costs to be incurred to collect the amounts due from Client under this agreement in the event of placement or referral for collection, plus a reasonable profit margin for the collection agency, attorney or other third party collection service.

**By signing the Client Registration Information form, Client acknowledges and declares that he or she knows and understands the above provisions**, either upon the same having been explained to him or her or having the opportunity to discuss it with Therapist, and that he or she agrees of his or her own accord to the above provision.