Beth Salvi-Hudgins, LICSW PO Box 874, Exeter, NH , 03833-0874 - bethsalvihudgins@gmail.com

CLIENT INFORMATION

Please print, fill out, take a picture or scan the document, and return this form along with the other 3 registration forms (group service agreement, release of information for an emergency contact, and release of information for your individual therapist). You can return these through email (bethsalvihudgins@gmail.com), text (603-247-2346) or postal mail (Beth Salvi-Hudgins, LICSW, PO Box 874, Exeter, NH 03833). If you do not have access to a printer, please email me and request a copy of the registration documents to be mailed to you. Thank you!

Name of Client _____ DOB_____

Mailing Address (Street, Town,Zip)_____

Client Address Used for Billing Insurance (If Different Than Mailing Address)

_____

Phone Number of Client (if over 18)
or Parent/Guardian (if under 18)

_____

Email of Client (if over 18)
or Parent/Guardian (if under 18)

_____

If you are enrolling a person under the age of 18 and you wish to provide me with their contact information, please do so.

Phone number _____ Email _____

PAYMENT INFORMATION

_____ I wish to self pay at the rate of $40/session.

_____ I wish to use my insurance to cover sessions. Copay amount (if you know) $_____

_____ I am aware that this group is not considered an in network service for my insurance. I will pay up front at the rate of $40/session and will receive a statement monthly that I can provide to my insurance to request reimbursement directly.

_____ Other Payment Type _____

If using insurance please take a picture/scan the front and back of the card and send this along with the registration forms. I will also need the following information:

Name of Family Member Who Carries the Insurance _____

DOB of Family Member Who Carries the Insurance_____

Authorization # (if needed) _____

(More on other side)

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Statements for client portion of service that they are responsible for will be billed out online every 2-4 weeks. Payments can be made online using paypal, by check sent to the mailing address above, or if you prefer me to keep an HSA or Credit Card on File to use for copayments, please include that information below.

Type of Card_____ Name on the Card_____

Street Address _____

Card Number_____ Exp_____ CVC_____

_____I acknowledge that it is my responsibility to update this office if my insurance changes in any way by sending in a copy of my new card. I understand that some insurance plans do not allow sessions to be billed more than 90 days from the time of service, so it is important to update this office with accurate insurance information promptly.

Signature _____ Date _____