Julia Clowney LICSW, LLC
475 N. Cleveland Ave, Suite 301
Saint Paul, MN 55105
651-797-4359

Registration

Patient Name _____

Street _____

City _____State _____ Zip code_____

Date of Birth_____ Marital status _____

Email address_____

Cell phone _____ Other phone _____

Emergency contact _____

Emergency contact phone _____

Primary Insurance Company _____

ID number _____ Group number _____

Secondary Insurance Company_____

ID number _____ Group number_____

Policy Holder if different from patient

Name _____

Relationship to patient _____ Phone _____

Address/City/State/Zip_____

_____ Date of Birth _____

Responsible Party (Who should get the bill for the patient's portion of the bill)

Name _____ Relationship_____

Address/City/State/Zip _____

_____Phone _____

Assignment & Release

I, 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 insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Julia Clowney LICSW LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship to patient Date