Associated Psychological Services, LLC.

Holmdel Executive Plaza
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APSwellness.com
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Client Registration

Please Print and Complete Form BEFORE Appointment

Name:______________________________________ Date of Birth: _______________ Age: __________

Home Address:____

Parent or Guardian Representative:____

Home Phone: ______________________ Cell: _________________________ Work: _______________

Email Contact: ____

Social Security #: _______________________________

Insurance Plan Holder Information

Name: ____ Date of Birth: ____________________________

Home Address: ____

Contact Phone: ___________________________________ Social Security #: _____________________

Employer: ____

Insurance Plan Information

Primary Insurance Plan:____

Member ID#: _____________________________________ Group #: ________________________

Secondary Insurance Plan (if applicable): ____

Member ID#: _____________________________________ Group #: ________________________

Emergency Contact

Name: ______________________________________ Phone: ________________________________

Relationship to Client: ________________________

Credit Card/Debit Authorization

Credit/Debit Card is required to be kept on file to secure payment for services rendered. As with ALL information, this too will be kept private and secure. No charges will be made without your permission, unless there is a balance due (Please see Client Services Agreement for further details regarding policy).

We require your credit card information to be on file for several reasons:

1) If you miss your appointment without giving the 24 hour notice, then we charge your card the missed appointment fee of your therapist's full fee. This fee cannot be submitted to insurance.
2) In the event that you have an outstanding balance past 60 days, you will be notified of this balance and your card will be charged for the outstanding balance, unless you choose to make alternative payment arrangements with your therapist.
3) If you have co-pays or are paying out-of-pocket, you have the option of using this card on file for these payments at the time of each session.

Required Debit/Credit Card to be on File: (Please check the appropriate card)

Visa______ MasterCard______ Discover______ Debit______
(American Express not accepted)

Expiration Date:______/______/______ CVV Code: ___________

Card Number_______________-_________________-_________________-______________

Name as it Appears on Card: ____

Credit Card Billing Address: ____

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I authorize the use of my credit/debit card to Associated Psychological Services. I give my permission to utilize the above information for session payments or my balance due.

Signature:____ Date: ______/______/______