

# RENEE D. RODGERS, LSCSW

CHRYSALIS, LLC

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## PATIENT INFORMATION & REGISTRATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact & Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Current Medical Physician: \_\_\_\_\_ Referred By: \_\_\_\_\_

## INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_ Identification #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have more than one insurance company?  Yes  No

Insurance Company #1: \_\_\_\_\_ Insurance Company #2: \_\_\_\_\_

Ins. Co. #1 Address: \_\_\_\_\_ Ins. Co. #2 Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Person Responsible for payment: \_\_\_\_\_

I authorize assignment of insurance benefits and payments to: \_\_\_\_\_ for covered expenses:

(Check one)  Yes  No

I authorize the release of any medical information necessary to process my insurance claim:

(Check one)  Yes  No

**I understand that I will be responsible for any charges not covered by insurance. I agree to give 24 hours notice if I am unable to make an appointment and I understand that I will be charged for any missed sessions or late cancellations if I do not provide such notice, except in the event of illness or emergency.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_