Bridges and Pathways Counseling Services
Twin Cities

Registration Form

Name:_____ **Date of Birth:** _____

Name(s) of Parents of Minor: _____

Mailing Address: _____
Number, Street, Unit or Apartment City, State, Zip Code

Telephones we can call and leave messages. Please list them in your order of preference and circle type/location. Calls may be placed by the clinician, billing/insurance clerk, or other staff member.

1. _____ **Cell Home Work** **2.** _____ **Cell Home Work**

Relationship Status: ☐ **Single** ☐ **Domestic Partner** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Employer/school: _____

Occupation: _____

☐ **Full Time** ☐ **Part Time** ☐ **Self Employed** ☐ **Not Employed** ☐ **Retired** ☐ **Active Military**

Emergency Contact: _____
Name Phone Relationship to client

Person responsible for payment, if other than client:_____

Insurance Company: _____

Policy Holder Name and DOB (enter self, if client):_____

ID or MA #:_____ **Group or Account:** _____

Insurance contact phone: _____

Therapist and Billing may send correspondence to the address above? _____**YES** _____**NO**

Revised: 12 20 20