AMY BARTEL, LMFT
LUMINOUS THERAPY, INC.
3750 W. Main St., Suite 168
Norman, OK 73072
Phone: (405) 365-3728 Fax: (405) 321-8581

Client Registration

Name:_____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age:_____ Social Security #: _____- _____- _____

Address:_____

City: _____State:_____ Zip:_____

Home Phone: (_____)_____ Cell: (_____)_____

Email:_____

Ethnicity:_____ Relationship Status: _____

Employer:_____ Occupation:_____

Do we have your permission to:

Leave a message via home/cell phone? Yes__ No__

I would like an appointment reminder via: Text _____ Email _____ None _____

Financially Responsible Party:

Name_____ _____Phone (_____)_____

Address:_____Relationship:_____

Emergency contact:

Name_____ _____Phone (_____)_____

Relationship to client:_____

I hereby authorize Amy Bartel, LMFT of Luminous Therapy, Inc. to contact the above listed person if Therapist believes that Client is in need of emergency medical or psychiatric care.

Signature of Responsible Party: _____ Date: _____

Circle how you first heard of Amy Bartel, LMFT: friend, family member, pastor, doctor, internet

Referred by:_____

Insurance Information:

Primary Insured Name: _____

Relationship to Client: _____ Phone#:(_____)_____

Address:_____

Date of Birth: _____SS#: _____

Employer:_____

Insurance Company: _____ Phone#:(_____)_____

Policy ID#_____ Group ID#_____

Plan ID#_____

Claims Address: _____

I _____ authorize Amy Bartel, LMFT of Luminous Therapy, Inc. to _____ release

and/or _____ obtain information regarding myself, or client: _____

to/from insurance company: _____to obtain benefit

information and for billing purposes.

Signature of Responsible Party: _____Date: _____

COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

IF NO INSURANCE INFORMATION IS FURNISHED TOTAL FEE IS DUE AT TIME OF SERVICE.

24 HOUR CANCELLATION NOTICE IS REQUIRED TO AVOID A FEE.

Primary Care Physician Information:

Primary Care Physician: _____

Physician aware you are seeking counseling at this time? Yes_____ No_____

Psychiatrist: _____

Psychiatrist aware you are seeking counseling at this time? Yes _____ No _____

I _____ authorize Amy Bartel, LMFT of Luminous Therapy, Inc. to _____ release and/or _____ obtain information regarding myself, or client: _____ to/from psychiatrist/primary care physician: _____ for the purpose of consultation between medical providers for the benefit of client's treatment.

Signature of Responsible Party: _____ Date: _____

For Private Pay Clients: The agreed upon Out of Network fees are: _____

I understand that I am financially responsible to Therapist for all charges.

Signature of Responsible Party: _____ Date: _____