Sexual Assault Center

Adult Client Registration Form

PATIENT INFORMATION

Legal Last Name	First	Middle	Relationship Status (Circle One) Single / Married / Divorced / Separated / Widowed / Living Cooperatively		
Client's Preferred Name	**Former Name**	**Birth Date** *xx / xx / xxxx* / /	**Age**	**Sex** ❑F ❑M	**Gender:**

Race:
❑Alaskan Native ❑ Native American (or American Indian) ❑Asian ❑Black (or African American)
❑Native Hawaiian ❑Pacific Islander ❑White ❑Decline to specify ❑ _____

Ethnicity
❑ Hispanic/Latino ❑ Non-Hispanic./Latino
❑ Decline to Specify

Client's Street Address/P.O. Box	City	State	Zip Code	Social Security — —
County of Residence	Does anyone in the client's household live or work in Davidson County? ❑ Yes ❑No			**Cell Phone No.** ( )
Occupation	**Employer**			**Employer Phone No.** ( )

Preferred method of contact ❑Phone ❑Email **Email:**

Please indicate the primary insurance: Provide a copy of current insurance card(s)
❑Aetna ❑BCBS ❑Cigna ❑Medicare ❑UnitedHealthcare ❑Optum ❑Amerigroup ❑BlueCare/TN care ❑United Healthcare Comm. Plan
❑Other_____ ❑ None __

Primary Member ID: _____

Member Name: _____ **SSN:** _____ **DOB:** _____

Please indicate the secondary insurance (if applicable):
❑Aetna ❑BCBS ❑Cigna ❑Medicare ❑UnitedHealthcare ❑Optum ❑Amerigroup ❑BlueCare/TN care ❑United Healthcare Comm. Plan ❑Other_____

Secondary Insurance Member ID: _____

Who is the primary care physician?_____ Do you give SAC permission to speak to the PCP? ❑Yes ❑No

Family - Household income:

❑Less than $10,890	❑$18,531- $22,350	❑$29,991- $33,810	❑$40,001- $45,000	❑$60,001 –$80,000
❑$10,891- $14,710	❑$22,351- $26,170	❑$33,811- $37,630	❑$45,001- $50,000	❑$80,001 -$100,000
❑$14,711-$18,530	❑$26,171- $29,990	❑$37,631- $40,000	❑$50,001- $60,000	❑Over $100,000

Number of people living in household:_____

How did you hear about us?
❑ Website ❑ Crisis Line ❑ Hospital ❑ Doctor ❑ Nurse ❑Other _____
❑ Family ❑ Friend ❑ Teacher ❑ School Counselor ❑ Community Health Fair ❑ Card/Pamphlet

IN CASE OF EMERGENCY

Name	Relationship to SAC Client	Home Phone ( )	Cell Phone ( )

By signing this form, I authorize the Sexual Assault Center to contact the above listed person in the case of an emergency.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the "Sexual Assault Center". **I also authorize the Sexual Assault Center or insurance company to release any information required to process my claims.** I understand that I am financially responsible for any balance. The insurance co-pay will be determined from information obtained from the insurance company. If the actual co-pay amount differs from the amount listed, I will be responsible for the difference.

I understand that payment is expected on the day of each appointment before each session begins, and that I will be charged according to the Attendance Policy for missed appointments not cancelled 24 hours in advance.

X_____
CLIENT/GUARDIAN SIGNATURE DATE