How To Life Consultants, LLC
Edith D Johnston PhD LPC CRC

P.O. Box 301
Delta, CO 81416
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Identity and Magnificent Expression
Know Yourself and Create Your Desired Outcomes

A psycho-education therapy group (CPT 90853)
With Edith D Johnston PhD LPC NCC CRC

Referral / Registration Form

Section 1: Participant Information

Name: _____ Today's Date _____

Address: _____ City: _____ State: _____ Zip:_____

Email: _____ Cell Phone: _____ Home Phone: _____

Work Phone: _____ Sex _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____ Phone: _____

Person to contact in an Emergency: _____ Phone: _____

_____ (Initial) I hereby agree to attend all 12 (2 hour) sessions and actively participate to the best of my ability.

Section 2: Referral Information

Referred by: _____

Contact Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

I, _____, give permission for exchange of information between _____

And Edith D Johnston PhD LPC and have provided a release of information with specifics of information to be released and time period ROI is effective.

Section 3: Payment (please initial those appropriate)

_____ I will pay cash for the 12 (2 hour) sessions – total of $240.00

_____ I will use my insurance benefits. Read and sign below.

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1) I hereby assign medical benefits, including those from government-sponsored programs and other health plans to be paid to the therapist listed above. Photo copy of assignment is as good as the original.
2) I understand I am responsible for all charges, regardless of insurance coverage. Copays are due at time of session.
3) I give this office permission to release any information obtained during evaluations or treatment that is necessary to support any insurance claims on this account and secure timely payments to assignee.

Signature: _____

_____ Other payment arrangements – Specify: _____

Section 4: Insurance Information

Full name of Insured: _____ Relationship to participant: _____

Home address: _____ City: _____ State: _____ Zip: _____

Employer Name and Address: _____ Phone: _____

Insured's Date of Birth: _____

Primary Insurance Company: _____ Insurance ID #: _____

Group #: _____ Plan Name/ Number: _____

Insurance's Providers contact phone number: _____

Address to send claims to: _____

_____

Other Insurance: (provide same details as above)_____

_____

Please provide copies of insurance card(s).