THE CALLI INSTITUTE
a **balanced approach** to mental health

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REGISTRATION - Patient Information

Patient Full Name			Date of Birth
Gender Male Female	Address	City/State/Zip	
Main Phone – Hm or Cell? (circle one)	Secondary Phone – hm or cell	Email address:	
Emergency Contact Name		Emergency Contact phone	

I want to sign up for the portal: Yes / No Appointment reminders via: Text Email Voice Message

Billing Information

Responsible billing party full name		Relationship to patient Self Spouse Parent Other _____
Billing Address	City/State/Zip	

Billing Phone	Leave Msg? Yes No	Private Pay ? Yes No	Private Pay $ amount

I understand that I am ultimately responsible for payment to Calli Counseling, PLLC for any and all services rendered due at the time of visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

Signature **Date**

Primary Insurance Information

Policy Holders Name	DOB	Insurance Company	
Policy Holder address	Phone number	Member ID #	Group ID #
Relationship to Patient Self Spouse Parent Other _____		Do you have secondary insurance? Yes No	

Will this be through an Employee Assistance Program? EAP? Yes No
If so, please provide authorization number_____

I authorize The Calli Institute, LLC to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to Calli Counseling, PLLC. I understand that I am responsible for payment for services rendered by Calli Counseling, PLLC, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in non-payment by my insurance company. I agree to notify The Calli Institute, LLC of any changes to my insurance coverage.

Signature **Date**