Ravita T. Omabu Okafor, MSW, LCSW
Registration Form

Client Information (please print, using <u>INK</u>):

_____ _____ _____
Last Name First Name Middle Name

_____ _____ _____
Street Address City/State Zip Code

CONTACT INFORMATION			
Home Number:	Cell Number:	Work Number:	Email address:

May I contact you at the above-listed places? Yes or No **May I text you?** Yes or No

Employer _____

Date of Birth _____ Marital Status _____ SS# _____

Emergency Contact: Name: _____

Relationship: _____ Telephone Number: _____

Insurance Coverage Information			
Company:		Policy ID #:	
Policyholder's Name:		Policyholder's DOB/SS#:	

Do you have additional insurance coverage: _____

If so, please provide relevant information: _____

_____

I, the undersigned, certify that I have insurance coverage with _____ (company) and assign directly to Ravita T. Omabu Okafor, MSW, LCSW all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. I authorize Ravita T. Omabu Okafor, MSW, LCSW to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions. My signature also affirms my receipt of a privacy practice notice.

_____ _____ _____ _____
Responsible Party Signature Responsible Party's Printed Name Relationship Date