Karen Wiens, LCSW, Psychotherapist, P. C. kwienslcsw@comcast.net cell 719-641-9859 off 719 632-6202
Licensed Clinical Social Worker Box 2004 • 212 Washington St, Monument, CO 80132

PATIENT REGISTRATION FORM

PLEASE COMPLETE ALL AREAS

PATIENT INFORMATION

Responsible Party Information		Spouse Information	
Name	____________________	Name	____________________
DOB	____________________	DOB	____________________
Street	____________________	Street	____________________
City/ST/zip	____________________	City/ST/zip	____________________
HP	____________________	HP	____________________
WP	____________________	WP	____________________
Cell	____________________	Cell	____________________
Email	____________________	Email	____________________
Employer	____________________	Employer	____________________

Payment is expected at the time of service or by end of day, unless other arrangements have been agreed upon.

Personal balances will be assessed $5.00 per month re-billing fee if not paid in full each month. Payments are accepted as cash, check, or Zelle.

AUTHORIZATION: The above is warranted to be true. I agree to be responsible for the charges incurred. If collection/attorney action is required, I agree to pay all costs of collection, including reasonable attorney's fees.

____ ____________________

signature of responsible party date