Daphna Steier, PsyD
2910 E. Madison St., Suite 208
Seattle, WA 98122
(206) 525-9665

New Client Registration Form

Date _____

Name _____ Age _____ Date of birth _____

Address _____ City _____ Zip _____

Email: _____

Cell phone _____ May I call you at this #? _____ May I text you this #? _____

Home phone _____ May I call you at this #? _____

Work phone _____ May I call you at this #? _____

Employer _____ Occupation _____

Who referred you to Dr. Steier? _____

Billing, Insurance, and Health Information

Person responsible for bill _____ Relationship to you _____

Contact information if other than self_____

1. Primary Insurance _____

Name of insured_____

Subscriber # _____ Subscriber DOB _____ Group # _____

2. Secondary Insurance _____

Name of insured_____

Subscriber # _____ Subscriber DOB _____ Group # _____

Emergency Contact

By providing the below information, I am allowing Dr. Daphna Steier to contact this person should there be an emergent reason to do so. No one will contact this person unless there is an emergency.

Name _____ Relationship to you _____

Contact Information _____

Signature

Your signature below indicates that you have read Dr. Steier's Policy Statement and Notice of Policies and Practices to Protect the Privacy of Health Care Information and agree to its terms.

_____

Signature Date

Thank You!
Revised 2/20