Lucinda Thimm-Jurado, MSSW, LCSW
Wisconsin Therapy Center LLC
6410 Enterprise Lane, Suite 130
Madison, WI 53719
Phone: (608) 819-8800
Fax: (608) 819-8899

REGISTRATION FORM

(Please Print)

Today's date:	Whom can we thank for the referral?								
Primary Care Physician (PCP):			PCP Clinic Name:						
PCP Clinic Address:				PCP Clinic Phone:					

CLIENT INFORMATION

❑ New Client	❑ Returning Client	Email:		OK to email? ❑ Y ❑ N		
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms	Last Name:	First Name:	Middle Name:			
Street Address:		Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed				
City:		Spouse / Significant Other's Name:				
State:	ZIP:	Soc. Sec #:	Birth date: / /	Age:	Sex: ❑ M ❑ F	

Phone Numbers: (please star preferred #)	OK to contact you here?	OK to leave a message?
Home:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only
Work:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only
Cell:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only

Occupation	❑Employed	❑Homemaker	❑Disable	❑Laid Off	❑Retired
Employer:				Length of Employment:	
Student: ❑ Full Time ❑ Part Time ❑ No	School:			Grade:	

Referred to Clinic by:	❑PCP	❑Insurance	❑Psychiatrist	❑Therapist	❑Family	❑Friend	❑Website	❑Hospital	❑Other
Name of Person who referred you:									

BILLING INFORMATION – RESPONSIBLE PARTY

(PERSON RESPONSIBLE FOR PAYING THE BILL)

Last Name:	First Name:	Middle Name:	
Sex: ❑ M ❑ F	DOB: / /	Relationship to Client:	Occupation:
Soc. Sec #:	Employer:		Employer's Phone #:
Employer's Address:			Length of Employment:

Phone Numbers:	OK to contact you here?	OK to leave a message?
Home:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only
Work:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only
Cell:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only
Email:	❑ Yes ❑ No ❑ Emergency Only	❑ Yes ❑ No ❑ Emergency Only

If client is a minor, please list parental information.

Mother's Name:		Father's Name:	
Mother's Address:		Father's Address:	
Preferred Phone#:	❑ Home ❑ Work ❑ Cell	Preferred Phone#:	❑ Home ❑ Work ❑ Cell
Employer (if applicable):		Employer (if applicable):	

Name of Other Persons in Household	Gender	Birth Date	Relationship to Client
	❑M ❑F		
	❑M ❑F		
	❑M ❑F		
	❑M ❑F		
	❑M ❑F		
	❑M ❑F		

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INSURANCE INFORMATION

(PLEASE BRING YOUR INSURANCE CARD TO THE INITIAL APPOINTMENT SO WE MAY MAKE A COPY)

Primary Insurance Co.:	Address (claims):		Phone:
Subscriber/ID #:	Group/File #:	Deductible:	Co-Payment:
Full Name of Policy Holder:	**DOB:**	**Relationship to Client:**	
Home Address (if different from client):		Mental Health Coverage Limits:	
Employer:			
Is Referral/Pre-Authorization Required? ❑ **Yes** ❑ **No**		**Has Pre-Authorization Been Obtained?** ❑ **Yes** ❑ **No**	
Terms of the Referral:		Authorization # (if applicable):	
Secondary Insurance Co.:	Address (claims):		Phone:
Subscriber/ID #:	Group/File #:	Deductible:	Co-Payment:
Full Name of Policy Holder:	**DOB:**	**Relationship to Client:**	
Home Address (if different from client):		Mental Health Coverage Limits:	
Employer:			
Is Referral/Pre-Authorization Required? ❑ **Yes** ❑ **No**		**Has Pre-Authorization Been Obtained?** ❑ **Yes** ❑ **No**	
Terms of the Referral:		Authorization # (if applicable):	

SUMMARY OF THE CONTENTS OF THE NOTICE OF PRIVACY PRACTICES FORM

- Your protected health information may be used or disclosed with your consent for purposes of payment and health care operations.
- Your signature on our patient registration indicates your consent for the release of information for the above purposes.
- The use or disclosure for purpose of treatment or for purposes outside those above, is permitted ONLY with your written authorization on a separate form designated for that purpose.
- I may disclose information without your consent or authorization under circumstances of Child Abuse, Adult and Domestic Abuse, Health Oversight, Judicial or Administrative Proceedings, Serious Threat to Health or Safety, Worker's Compensation, or for Law Enforcement purposes.
- Your rights and my duties are summarized in this document. I have received notice of cost of service in writing.
- I have received and reviewed the Wisconsin Therapy Center LLC (WTC) Notice of Privacy Practices.

SUMMARY OF THE CONTENTS OF CLIENT RIGHTS

I acknowledge that:

- I have been informed of my rights as a client of Wisconsin Therapy Center LLC as outlined in the Client Rights.
- I have received and reviewed the Wisconsin Therapy Center LLC Client Rights and Client Registration Form.
- I consent to treatment as outlined by my therapist and in accordance with the Client Rights Form.
- Unless otherwise specified, I give permission to contact my primary care physician, and to communicate with my insurance company, managed care provider, and/or billing company for the purpose of billing and/or treatment. By scheduling appointments on LuciTJ.com, I give permission and I agree not to hold Lucinda Thimm-Jurado, LCSW, or Wisconsin Therapy Center LLC liable for the use of my email address to schedule appointments and send email reminders of appointments. I agree that the email address provided will be used to communicate regarding non-urgent matters.
- I understand that I am responsible for obtaining a referral for my insurance, and that it is my responsibility to contact my insurance company to verify my benefits. I understand that I am responsible for co-pay portions of benefits, deductibles and for cost incurred during any period in which I do not have a current referral, and for services which are not covered by insurance, such as school consultation, telephone therapy, correspondence, report writing, marital counseling, psychological testing, and case management. I understand that I am financially responsible for my entire bill.
- My signature gives the insurance company permission to make payment directly to Lucinda Thimm-Jurado, LCSW or Wisconsin Therapy Center LLC. Any payment received will be applied directly to my account. We reserve the right to seek legal means to secure reimbursement. This may include releasing names and information to collection agencies, attorneys, or the Court. I release Lucinda Thimm-Jurado, LCSW, and Wisconsin Therapy Center LLC from any legal responsibility or liability that may arise from the act of filing my insurance claims or scheduling my appointments on LuciTJ.com.
- I agree that a copy of this authorization is to be considered as valid as the original and may be used in place of the original.
- All appointments that are missed or cancelled with less than 24 hours notice are subject to billing. Insurance carriers do not pay for missed or cancelled appointments.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Lucinda Thimm-Jurado, LCSW, Wisconsin Therapy Center LLC. I understand that I am financially responsible for any balance. I also authorize Lucinda Thimm-Jurado, LCSW, Wisconsin Therapy Center LLC and my insurance company to release any information required to process my claims. I understand that this consent may be revoked by me at any time, except to the extent that action has already been taken. This consent remains valid until revoked by me in writing.

Client Name (Please Print)	*Client Signature*	*Date*

CONSENT TO TREAT A MINOR AUTHORIZATION:

I give Lucinda Thimm-Jurado, LCSW / Wisconsin Therapy Center LLC my consent for treatment of a ❑ minor ❑ incompetent/incapacitated individual

Client's Name (Please Print)	Date of Birth

Legal Authority: ❑ Parent of Minor ❑ Legal Guardian ❑ Personal Representative of Deceased ❑ Next of Kin or Other Family Member

Responsible Party Name (please print)	*Responsible Party Signature*	*Date*

Witness / Therapist Signature	*Date*