



**Between Us Associates, PLLC**  
Therapeutic Services To Navigate Life's Challenges

754 Chestnut Street, Suite 2 • Manchester, NH 03104  
Tel (603) 836-5003 • Fax (603) 836-5004

**Client Registration**

Today's Date: \_\_\_\_\_  
 Client Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Telephone: (Home) \_\_\_\_\_ (wk) \_\_\_\_\_  
 (cell1) \_\_\_\_\_ Belongs to: \_\_\_\_\_  
 (cell2) \_\_\_\_\_ Belongs to: \_\_\_\_\_

Please indicate with an \* at which numbers we may leave a message.

Email: \_\_\_\_\_ Belongs to: \_\_\_\_\_  
 Email2: \_\_\_\_\_ Belongs to: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
 (with address if different from child's)

Parent/Guardian: \_\_\_\_\_  
 (with address if different from child's)

Any other children, name(s), ages: \_\_\_\_\_  
 \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Fax # \_\_\_\_\_

Other providers' information:

Names	Service	Telephone / Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

How were you referred to Between Us Associates? \_\_\_ Insurance Company \_\_\_ Friend  
 \_\_\_ Yellow pages \_\_\_ Therapist \_\_\_ Mailing \_\_\_ Online locator directory \_\_\_ Other  
 Comments, and who may we thank for referring you (with address if possible)? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Party Financially Responsible:**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_  
 Phone (if different from above): \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Which payment type? (mark one)  Private Pay  Out-of-network  Insurance  
 HSA/Flex Fund  Victim Assistance Fund  EAP  
 Other Third Party Payer, describe \_\_\_\_\_  
\_\_\_\_\_

**Insurance Information:**

Policyholder Full Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_ Group #: \_\_\_\_\_

Policyholder ID #: \_\_\_\_\_ Phone # benefits: \_\_\_\_\_

Identified Client ID #: \_\_\_\_\_

Claims Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Co-pay amount: \$ \_\_\_\_\_ Co-insurance \$ \_\_\_\_\_ Deductible amount \$ \_\_\_\_\_ met? Y N  
If N, remaining deductible? \$ \_\_\_\_\_

UR Contact Name: \_\_\_\_\_

UR Contact Phone #: \_\_\_\_\_ ext. \_\_\_\_\_ Fax #: \_\_\_\_\_

Insurance Authorization #: \_\_\_\_\_ # of sessions authorized: \_\_\_\_\_

If applicable, authorization period, from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

Is there a secondary insurance?  Y  N

Insured's Name: \_\_\_\_\_ Insured's Social Sec. #: \_\_\_\_\_

Insured's D.O.B.: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Emergency Contact People:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

(By filling in emergency contact person information you are authorizing BUA to contact this person in an emergency.)

**Client Authorization:**

I understand that I am fully responsible for any fees for professional services provided to me or my dependents. If I am using my insurance, my signature below authorizes Between Us Associates to submit claim forms for me directly to my insurance company, but does not guarantee payment of claims. I authorize the release of any medical or other information required by my insurance company to receive authorization for services or to process claims for services to me or my dependents.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Internal Use: Fee: \$ \_\_\_\_\_

Diagnosis: I. \_\_\_\_\_  
\_\_\_\_\_