

**Ginger Moriarty, MSW, LICSW  
Client Registration**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home address: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Who to thank for the referral: \_\_\_\_\_

**Payment Information**

Full name of responsible party: \_\_\_\_\_

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

Phone number: \_\_\_\_\_

Insurance Company (if applicable): \_\_\_\_\_

Whose insurance is this? \_\_\_\_\_

Relationship of insurance holder to the client: \_\_\_\_\_

Insurance Co. Phone number: \_\_\_\_\_

ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Please list any medication you are currently taking: \_\_\_\_\_

\_\_\_\_\_ dose: \_\_\_\_\_

Please briefly explain why you are seeking counseling and what you hope to gain:

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I understand that I am financially responsible for all charges and agree to pay for services. I authorize Ginger Moriarty, LICSW to release to my insurance company any information necessary to process my claim.

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