



P.O. Box 2469
306 N. Queen St.
Kinston, NC 28502
Phone: 252-208-0027
Fax: 252-208-0029
Email: esaylors@encpsych.com

Date: _____

Registration Form

Client's Name: (first) _____ (middle) _____ (last) _____

Date of Birth: _____ Sex: (M/F) SSN#: _____

Address: (street) _____ (city) _____
(state) _____ (zip code) _____ (home #) _____ (cell/work #) _____

Referred by: _____ Seen another Mental Health provider in past year? (Y/N)

Insurance Information

Insurance provider:(circle) None/Medicaid/Medicare/NC Healthchoice/BCBS/Magellan/Cigna/Medcost/Tricare

Person responsible for bill, and address if different from above: _____

Primary Insurance Policy and group number: _____

Secondary Insurance Policy and group number (if applicable): _____

I authorize ENC Psychological Services, PLLC to file their services with my insurance company:
(signature) _____ (date) _____

Consent

I have read/received the HIPAA privacy practices and I consent to the treatment of myself/my child by ENC Psychological Services, PLLC. I understand that I have the right to consent to or to refuse treatment at any time. (signature): _____ (date) _____

In case of emergency, please name a friend or relative whom we may contact:
_____ (phone #): _____