

# Quo Vadis Therapy Center, LLC

Located at Arden Woods Psychological Services  
CLIENT INFORMATION/REGISTRATION FORM

Effective 2/1/16

Joseph W. Pribyl, MA, LMFT  
900 Long Lake Road, #320  
New Brighton, MN 55112  
Phone: 651-398-5847  
www.qvtherapy.com

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

Client Name: \_\_\_\_\_ Gender: M F Date of Birth: \_\_\_\_\_

Client Address: \_\_\_\_\_  
(Please provide contact information at which you are comfortable receiving correspondence from Quo Vadis)

Billing Address: (if different than above) \_\_\_\_\_

May we correspond by email? Y / N Email address: \_\_\_\_\_

Client Home Phone: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
(Please indicate which number is preferred and if it is NOT ok to contact you or leave messages at any of these numbers)

Marital Status: Single Dating Engaged Married Divorced Domestic Partner Widowed

Person filling out form, if not client: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

## INSURANCE INFORMATION – Complete if you intend to use insurance benefits for services provided

Primary Insurance: \_\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

Name of Primary Policy Holder Exactly as It  
Appears on the Card: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holder I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_

Policy Holder Mailing Address (if different from client's): \_\_\_\_\_

Policy Holder Phone: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

My signature below authorizes Quo Vadis Therapy Center/Arden Woods Psychological Services to bill and release all necessary information to my insurer noted above for the purpose of Quo Vadis Therapy Center, LLC to receive reimbursement for services provided to me. I understand that my signature here will apply to any/all insurance submissions. I also agree to the payment agreement/policies provided to me under separate cover.

Responsible Party Signature \_\_\_\_\_ Relationship to Client \_\_\_\_\_ Date \_\_\_\_\_

Are you involved in any legal proceedings which could involve your therapist? Y / N If yes, please describe:  
\_\_\_\_\_

How were you referred to Quo Vadis Therapy Center, LLC? \_\_\_\_\_  
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## For Office Use Only:

Dx: \_\_\_\_\_ DX Description \_\_\_\_\_ Fee \_\_\_\_\_ Adj \_\_\_\_\_ CP \_\_\_\_\_