Affiliates in Behavioral Health, LLC

PATIENT INFORMATION

Last Name _____First Name _____ Middle Initial _____

Address _____City, State, Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Gender _____

Social Security # _____ Marital Status _____ Student Status _____ Date of Birth _____

Employer Name and Address _____

SPECIFY WHICH PHONE NUMBER(S) TO CONFIRM YOUR APPOINTMENTS Home? _____ Work? _____
Cell? _____

INSURANCE POLICY HOLDER

Last Name _____ First Name _____ Middle Initial _____

Address _____ City, State, Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____ Gender _____

Social Security # _____ Marital Status _____ Date of Birth _____

Relationship to Patient _____ Employer Name and Address _____

INSURANCE INFORMATION:

Address for Claims _____

Phone # _____ Effective Date _____ ID# _____

Grp # _____ Is pre-authorization required for your insurance?___ Have you obtained authorization for this visit?___

Do you owe a co-pay/co-insurance amount? _____ How much? _____

Is there additional insurance coverage? If yes, please ask for form.

GUARANTOR INFORMATION (FINANCIALLY RESPONSIBLE PARTY WHO WILL SIGN BELOW)

Name _____ Relationship to Patient _____ Social Security Number _____

Address _____ City, Sate, Zip _____

Employer _____ Employer Phone _____

ADDITIONAL INFORMATION

Referred by? _____ In case of emergency whom should we contact? _____

Relationship? _____ Phone Number _____

I acknowledge that all information provided above is true and accurate. I understand that my insurance information is being verified and that I may be billed as self-pay if I fail to provide accurate insurance information. I understand that returned checks will be subject to fees. I understand that I will be charged for appointments canceled with less than 24 hours notice and for appointments that I fail to cancel and/or show up for. I understand that any accounts placed for collections will incur a late fee. I acknowledge that I have been informed of my rights of privacy and am authorizing treatment.

Signed _____ Relationship to Patient _____ Date _____