

Behavioral Healthcare

Child/Adolescent Registration Form

C O N S U L T A N T S

Date: _____ Therapist: _____

Client Information

First Name:	<input type="text"/>	MI:	<input type="text"/>	Home Phone:	<input type="text"/>	-	<input type="text"/>			
Last Name:	<input type="text"/>			Work Phone:	<input type="text"/>	-	<input type="text"/>			
Address:	<input type="text"/>			Birth Date:	<input type="text"/>	/	<input type="text"/>	/	Age	<input type="text"/>
	<input type="text"/>			Sex:	<input type="checkbox"/>	Male	<input type="checkbox"/>	Female		
City:	<input type="text"/>	St:	<input type="text"/>	Zip:	<input type="text"/>			Soc. Sec. #:	<input type="text"/>	
School Name:	<input type="text"/>			Grade:	<input type="text"/>					
Family Physician:	<input type="text"/>	Address:	<input type="text"/>							
Whom may we thank for referring you?	<input type="text"/>									

Father's Name

Name:	<input type="text"/>	Home Phone:	<input type="text"/>	-	<input type="text"/>		
Address:	<input type="text"/>	Work Phone:	<input type="text"/>	-	<input type="text"/>		
	<input type="text"/>	Cell Phone:	<input type="text"/>	-	<input type="text"/>		
City:	<input type="text"/>	St:	<input type="text"/>	Zip:	<input type="text"/>	Soc. Sec. #:	<input type="text"/>
Employer:	<input type="text"/>	Occupation:	<input type="text"/>				

Mother's Name

Name:	<input type="text"/>	Home Phone:	<input type="text"/>	-	<input type="text"/>		
Address:	<input type="text"/>	Work Phone:	<input type="text"/>	-	<input type="text"/>		
	<input type="text"/>	Cell Phone:	<input type="text"/>	-	<input type="text"/>		
City:	<input type="text"/>	St:	<input type="text"/>	Zip:	<input type="text"/>	Soc. Sec. #:	<input type="text"/>
Employer:	<input type="text"/>	Occupation:	<input type="text"/>				

Primary Insurance

Health Insurance Plan:	<input type="text"/>	ID Number:	<input type="text"/>
Employer:	<input type="text"/>	Group Number:	<input type="text"/>
Behavioral Healthcare Plan:	<input type="text"/>	Phone:	(<input type="text"/>) - <input type="text"/>
Claim Address:	<input type="text"/>		
	<input type="text"/>		
City:	<input type="text"/>	St:	<input type="text"/>
		Zip:	<input type="text"/>

Insured / Policy Holder

First Name:	<input type="text"/>	MI:	<input type="text"/>	Last Name:	<input type="text"/>
		Birth Date:	<input type="text"/> / <input type="text"/> / <input type="text"/>	SS #:	<input type="text"/>
Client relationship to insured:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Self	<input type="checkbox"/> Other	<input type="text"/>
Is percertainment required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Percert. #:	<input type="text"/>	

Secondary Insurance

Health Insurance Plan:	<input type="text"/>	ID Number:	<input type="text"/>
Employer:	<input type="text"/>	Group Number:	<input type="text"/>
Behavioral Healthcare Plan:	<input type="text"/>	Phone:	(<input type="text"/>) - <input type="text"/>
Claim Address:	<input type="text"/>		
	<input type="text"/>		
City:	<input type="text"/>	St:	<input type="text"/>
		Zip:	<input type="text"/>

Insured / Policy Holder

First Name:	<input type="text"/>	MI:	<input type="text"/>	Last Name:	<input type="text"/>
		Birth Date:	<input type="text"/> / <input type="text"/> / <input type="text"/>	SS #:	<input type="text"/>
Client relationship to insured:	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Self	<input type="checkbox"/> Other	<input type="text"/>
Is percertainment required?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Percert. #:	<input type="text"/>	

Assignment of Benefits & Release of Information

Acknowledgement of responsibility:

I, the undersigned, acknowledge that payment is due at the time of service unless payment arrangements and/or billing for assignable third party insurance benefits have been approved in advance. I understand that I am financially responsible for all charges not paid by my insurance company, unless they are not contractually chargeable to me.

Third party group/individual health insurance/managed care plans:

I hereby authorize Behavioral Healthcare Consultants to release information necessary to secure the payment of third-party benefits. I further authorize payment of third-party benefits directly to Behavioral Healthcare Consultants. I understand that I am required to pay insurance co-payments, if applicable, at the time of service. I authorize Behavioral Healthcare Consultants to use this signature as necessary to obtain the payment of third party insurance payments.

Worker's compensation Auto Motor Vehicle and Liability Claims:

I hereby authorize Behavioral Healthcare Consultants to release information necessary to secure the payment of third-party benefits. I understand that all services rendered to me will be my responsibility for payment in the event that my claim for Worker's compensation, auto insurance, or third party liability is denied.

Signature: _____ Date: _____
Client/parent/legal guardian