

Behavioral Healthcare

Client Registration Form

C O N S U L T A N T S

Date: _____ Therapist: _____

Client Information

First Name: MI: Home Phone: () -
Last Name: Work Phone: () -
Address:
 Cell Phone: () -
 Birth Date: / / Age
City: St: Zip: Sex: Male Female
Marital Status: Single Married Other _____ Soc. Sec. #:
Family Physician: Address:

Whom may we thank for referring you?

Our staff may need to contact you by telephone regarding scheduling or other concerns. To protect your privacy, we will speak to you directly whenever possible. When you are not immediately available, we need your direction to leave messages or to use alternate phone numbers. *Please **initial** any of the following methods you wish us to use:*

- Leave messages on my home answering machine.
 Leave messages with persons answering my home telephone.
 Contact me at work. Leave messages for me at work.
 Do not leave a message if you cannot speak directly to me.
 Call my cell phone, leaving a message if I do not answer.

Other directions:

Responsible Party (if other than client)

Name: Home Phone: () -
Address:
 Work Phone: () -
 Soc. Sec. #:
City: St: Zip:
Relationship to Client: Spouse Child Self Other _____

Worker's Compensation / Motor Vehicle / Accident-Liability / N/A

Insurance Carrier: Phone: () -
Carrier Address:
 Adjuster's Name:
 Policy/Claim #:
City: St: Zip:
Date of Injury:
Attorney: Address:
Phone: City: St: Zip:

Primary Insurance

Health Insurance Plan:

ID Number:

Employer:

Group Number:

Behavioral Healthcare Plan:

Phone: () -

Claim Address:

City: St: Zip:

Insured / Policy Holder

First Name: MI: Last Name:

Birth Date: / / SS #:

Client relationship to insured: Spouse Child Self Other _____

Is certification required? Yes No Precert. #:

Secondary Insurance

Health Insurance Plan:

ID Number:

Employer:

Group Number:

Behavioral Healthcare Plan:

Phone: () -

Claim Address:

City: St: Zip:

Insured / Policy Holder

First Name: MI: Last Name:

Birth Date: / / SS #:

Client relationship to insured: Spouse Child Self Other _____

Is certification required? Yes No Precert. #:

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