PATIENT INFORMATION

Name:_____Age:_____Male/Female

Date of Birth:_____

Name of person completing form if other than the patient:_____
Your relationship to the patient:_____

Address:_____

_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Other Phone:_____

Best phone number to reach you? Home___ Cell___ Work___ Other_____

Emergency Contact
Name:_____
Phone Number:_____ Relationship to you:_____

Health Insurance Company: _____
Name of policy holder if other than the patient?_____
What is the policy holder's date of birth?_____
Address if different from above_____
_____

Secondary Health Insurance (coverage by more than one Health Insurance Company):
If you have secondary insurance, what company is it through?_____
Name of Policy Holder_____
Please provide further information (policy number, etc.) to us as soon as possible

Fees and Payments:
We expect payment in full at the time of service for your estimated portion including copayments, deductibles and non-covered items. As a courtesy, we bill some insurance companies directly. Mental health benefits can be reimbursed differently from other health care. It is your responsibility to find out what your insurance covers and if a preauthorization is required. For larger balances over $100, our office policy allows for regular monthly payments of $50 or more depending on your account balance. Arrangements must be made with our billing office staff. A finance charge of 1% per month (12% APR) will be assessed on all balances over 60 days. If you have any questions or problems regarding your account, please do not hesitate to call and discuss the matter with our billing office staff.

Assignment and Release: I have read and understand the above payment policy statement for Integrated Health and Behavior. I hereby authorize my insurance benefits to be paid directly to Integrated Health and Behavior. I am financially responsible for non-covered services. I also authorize the physician to release any information required for payment, which may include otherwise protected information.

Signed_____ Date_____

Print name:_____
If signing on behalf of someone else, what is your relationship to that patient?_____