PATIENT INFORMATION - 2020

DATE: _____

PATIENT NAME: _____ M OR F (CIRCLE ONE)

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT HOME PHONE: _____

PATIENT DATE OF BIRTH: _____

PATIENT SCHOOL NAME: _____

PARENT/GUARDIAN INFORMATION

MOTHER'S NAME: _____

MARITAL/LEGAL STATUS: _____

MOTHER'S ADDRESS: _____

MOTHER'S PHONE: _____

MOTHER'S E-MAIL: _____

MOTHER'S EMPLOYER: _____ PHONE: _____

FATHER'S NAME: _____

MARITAL/LEGAL STATUS: _____

FATHER'S ADDRESS: _____

FATHER'S PHONE: _____

FATHER'S E-MAIL: _____

FATHER'S EMPLOYER: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO PATIENT: _____

CONTACT PHONE: _____

INSURANCE INFORMATION

PRIMARY CARRIER: _____

POLICY HOLDER NAME: _____

POLICY HOLDER ADDRESS: _____

POLICY HOLDER PHONE: _____

POLICY HOLDER DATE OF BIRTH: _____

MEMBER ID: _____ GROUP NUMBER: _____

SECONDARY CARRIER: _____

POLICY HOLDER NAME: _____

POLICY HOLDER ADDRESS: _____

POLICY HOLDER PHONE: _____

POLICY HOLDER DATE OF BIRTH: _____

MEMBER ID: _____ GROUP NUMBER: _____

AUTHORIZATIONS

ARE YOU THE PATIENT'S LEGAL GUARDIAN? YES OR NO

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS CLAIMS.
PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER (BEHAVIORAL SOLUTIONS, LLC OR FAMILY FIRST CENTER FOR AUTISM AND CHILD DEVELOPMENT) FOR MENTAL HEALTH SERVICES.
PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

I HAVE READ THE HIPAA NOTICE FORM.
PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY
PRE-CERTIFICATION REQUIRED? YES / NO ABA BENEFIT? YES / NO
DEDUCTIBLE: _____ CO-INSURANCE/CO-PAY _____
YEARLY OUT OF POCKET MAXIMUM _____