PHOENIX BEHAVIORAL HEALTH SERVICES, LLC

LAST NAME FIRST MI	PHONE	BIRTH DATE	AGE
ADDRESS	SS#	MALE ___ FEMALE ____	
CITY STATE ZIP	MARITAL STATUS - CIRCLE ONE SINGLE, MARRIED, DIVORCED, WIDOWED		
CLIENT'S EMPLOYER	EMAIL ADDRESS		
DESCRIPTION OF PROBLEM	WHO REFERRED YOU		

HOW DID YOU HEAR ABOUT US? (check)	PHONE BOOK ______	INTERNET _____	PERSONAL REFERRAL _______
	NEWSPAPER _____	DR. REFERRAL _____	INSURANCE PPO LIST _____
	COURT ORDERED ______	OTHER (please list)	

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE
SPOUSE OR PARENT(S) NAMES	SPOUSE'S OR PARENTS EMPLOYER	PHONE

BILING AND/OR INSURANCE INFORMATION (PLEASE LIST IN ORDER TO BE SUBMITTED).

COMMERCIAL INSURANCE _____	PRIMARY INS. CO	SECONDARY INS. CO
MEDICARE ______	NAME OF POLICY HOLDER	NAME OF POLICY HOLDER
MEDICAID ______	BIRTH DATE OF POLICY HOLDER	BIRTH DATE OF POLICY HOLDER
MEDICAID HMO PLAN _______	ID#	ID#
PRIVATE PAY _____	GROUP # OR NAME	GROUP # OR NAME
ADDRESS OF POLICY HOLDER (if different than above)		

All professional services are charged to the client, necessary forms will be completed to help expedite insurance carrier payments by our billing services. However, the client is responsible for all fees regardless of insurance coverage.
We ask that insurance clients make their co-payments at the time of each visits.
Private pay clients must pay the entire amount at the time of service unless prior payment arrangements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any information necessary to determine benefits associated with visits to the Phoenix Behavioral Health Services, LLC and request payment directly to them for services provided. I recognize and accept responsibility for any balance remaining after payment of benefits associated with my health insurance policy

SIGNATURE DATE:

FOR OFFICE USE ONLY

DATE CALLED	STAFF PERSON
THERAPIST	REQUESTED: YES NO

CODES PRIMARY DIAGNOSIS

THERAPIST SIGNATURE

FORM UPDATED 10-21-19