PHOENIX BEHAVIORAL HEALTH SERVICES, LLC

LAST NAME	FIRST	MI	PHONE	BIRTH DATE	AGE

ADDRESS	SS#	MALE ___ FEMALE ____

CITY	STATE	ZIP	MARTIAL STATUS - SINGLE MARRIED . WIDOWED DIVORCED

EMAIL ADDRESS- required	Client Employer

DESCRIPTION OF PROBLEM	WHO REFERRED YOU

FOR MINOR CLIENTS - IS THERE A CUSTODY AGREEMENT - YES (Please provide a copy) NO

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

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE

SPOUSE OR PARENT(S) NAMES	SPOUSE'S OR PARENTS EMPLOYER	PHONE

GUARDIAN NAME	GUARDIAN ADDRESS	GUARDIAN PHONE

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

COMMERCIAL INSURANCE _____	PRIMARY INS. CO	SECONDARY INS. CO
MEDICARE _____	NAME OF POLICY HOLDER - required	NAME OF POLICY HOLDER - requried
MEDICAID _____	BIRTH DATE OF POLICY HOLDER - required	BIRTH DATE OF POLICY HOLDER-required
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. Phoenix will bill your insurance as a courtesy. However, the client is responsible for all fees regardless of insurance coverage. We ask that insurance clients make their co-pays at the time of each session. Private pay clients must pay the entire amount at time of visit, unless other payment agreements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any information necessary to determine benefits associated with visits to 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

Revalidation of HIPAA & Consent to Treat and Contact

I acknowledge receipt of the HIPAA Notice of Privacy Practices, grant permission to Phoenix Behavioral Health Services, LLC. to contact me and grant consent to treat and acknowledge program policies & procedures of Phoenix Behavioral Health Services, LLC.

CLIENT or LEGAL REPRESENTIVE SIGNATURE **DATE**