



Arbor Mental Health Center

CLIENT INFORMATION

Name: _____ DOB: ____/____/____ Gender: M F

First MI Last

Address: _____ City: _____ State: ____ Zip: _____

Telephone: Cell: (____) _____ - _____ Home: (____) _____ - _____ Work: (____) _____ - _____

Marital Status: Single Married Employer/School: _____

Other

****All Relevant Fields Required****

Primary Insurance Carrier: _____

Policyholder Name: _____ DOB: ____/____/____ Relationship to Client: _____

Address of Policyholder (if different than client) _____

Member ID: _____ Group Number: _____

Policyholder Telephone: (____) _____ - _____ Policyholder Employer: _____

Employee Assistance Program authorization number (if relevant): _____

Secondary Insurance Carrier: _____

Policyholder Name: _____ DOB: ____/____/____ Relationship to Client: _____

Address of Policyholder (if different than client) _____

Member ID: _____ Group Number: _____

Policyholder Telephone: (____) _____ - _____ Policyholder Employer: _____

Person financially responsible for this account *if other than client*:

Name: _____ Relationship to Client: _____

Address (if different than client): _____ City: _____ State: ____ Zip: _____

Telephone: Cell: (____) _____ - _____ Home: (____) _____ - _____ Work: (____) _____ - _____

AUTHORIZATION FOR THE PAYMENT OF BENEFITS

- I hereby authorize payment directly to Arbor Mental Health Center, if otherwise payable to me, for counseling and/or neuropsychological testing services rendered at this clinic. I understand and accept all financial responsibility for the deductible amount and for any outstanding amount after payment of such benefits and denial of payment. I will notify Arbor Mental Health Center of any changes to my coverage within 14 days of the change.
- I hereby authorize Arbor Mental Health Center, to release the following information necessary to process my medical insurance claims and the claims of my family members covered by my medical insurance company: Name, date of birth, diagnosis, progress notes, treatment plans, name of insurance company, subscriber's name, and effective date of policy, policy number, group number, and date and times services are provided.
- I understand that this authorization is revocable by me at any time but that my revocation of this authorization will result in my personally assuming financial responsibility for services rendered on my behalf that otherwise would have been reimbursed by my insurance company. I understand that a photocopy of this assignment shall be considered as valid as the original.

Signature of Client or Legal Guardian

Date