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**