Success Behavioral Health Services *"We always have your success in mind"*

PATIENT INFORMATION

Date:_____/_____/_____

Last Name________________________First____________________________M________________

Address____

City____________________________________State_________________Zip_________________

E-mail ____@ __________________________

Phone (home)_______________________________ (Cell)_________________________________

Male/Female   Date of Birth _____/_____/_____ SS#_____/____/_______ Marital Status________

Place of Employment________________________________Occupation______________________

Is Patient's Condition related to: Employment   Auto Accident   Other Accident

Primary Care Physician_________________________ **Psychiatrist** ___________________________

Insurance Information:

Does patient have insurance: Yes   No   Name of Insurance: _______________________________

Is there another benefit plan/secondary insurance? ____________________________

Patient relationship to Insured: Self   Spouse   Child   Other

Name and address of subscriber: ____

Subscriber's Date of Birth ______/______/______   Subscriber's SS# ________/_____/_________

ID # : _________________________________   Medicaid # ____________________________

I understand if my insurance requires pre-authorization/pre-certification for services, it is my responsibility to request it from my insurance company.

I authorize the release of any medical or other necessary information to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below. I authorize payment of medical benefits to the undersigned physician or suppler for services.

Printed Name : _________________________________   **Signature :** __________________________________

Receipt of 'Notice of Privacy Practices'

I acknowledge that I have been provided a copy of 'Notice of Privacy Practices'. I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving behavioral health services

____ ______________

Patient Name (please print) Date

____ ______________

Parent or Authorized Representative (if applicable) Date

____

Patient Signature

________________________________ ______________

Witness Date

FINANCIAL DISCLOSURE FOR 3RD PARTIES

Patient: ______________________________________

I give permission for Success in Mind to discuss financial matters, and/or accept payments on my behalf with the following:

____ ______________________________

Name Relationship to Patient

____ ______________________________

Name Relationship to Patient

____ ______________________________

Name Relationship to Patient

____ ______________________________

Name Relationship to Patient

This consent is for financial matters only. No discussion of treatment is authorized unless a separate consent is signed.

____ ______________________________

Patient Signature Date

Office Hours:

The office is open Monday through Thursday 8:00 AM to 6:00 PM and Friday hours by appointment.

Insurance Billing:

The office will file your insurance claims as a convenience to you. Co-payments are expected at the time of service. If your insurance requires pre-authorization for services, it is your responsibility to obtain that authorization.

Emergencies:

If you have a life-threatening emergency, call 911 or go directly to the emergency room. For non-life threatening emergencies, I will be glad to schedule a first-available appointment.

Missed Appointments/Cancellations:

A $60 fee will be assessed for a missed appointment. A cancellation not within 24-hours of a scheduled appointment is treated as a missed appointment.

Authorization:

I authorize my insurance company to reimburse Success In Mind for services rendered. I am responsible for deductibles and co-pays and collection fees necessary to collect on my account. I agree with the terms and conditions listed above.

Patient or Guardian:________________________________Date:_______________

Witness:____Date:_______________

Signature:____Date:_______________