# PATIENT INFORMATION

**Please print**

Name:_____Age: _____ Male ☐ Female ☐ Other ☐

Date of Birth: _____

Name of person completing form if other than the patient: _____

Your relationship to the patient: _____

Address:_____

_____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Other: _____

Best phone number to reach you? Home ☐ Cell ☐ Work ☐ Other ☐

Email address: _____ (we use this only if telehealth is needed)

**Emergency Contact:**

Name:_____

Phone Number:_____ Relationship to you:_____

**Health Insurance Company**:_____

Name of policy holder if other than the patient: _____policy holder's DOB:_____

Policy Holders Relationship to the Patient: _____

Address if different from above: _____

**Secondary Health Insurance (coverage by more than one Health Insurance Company):** _____

Name of Policy Holder: _____ policy holder's DOB: _____

**Fees and Payments**: We expect payment in full at the time of service for your estimated portion including copayments, deductibles and non-covered items. As a courtesy, we bill some insurance companies directly. Mental health benefits can be reimbursed differently from other health care. It is your responsibility to find out what your insurance covers and if a preauthorization is required. For larger balances over $100, our office policy allows for regular monthly payments of $50 or more depending on your account balance. Arrangements must be made with our billing office staff. A finance charge of 1% per month (12% APR) may be assessed on all balances over 60 days. If you have any questions or problems regarding your account, please do not hesitate to call and discuss the matter with our billing office staff.

**Assignment and Release**: I have read and understand the above payment policy statement for Integrated Health and Behavior. I hereby authorize my insurance benefits to be paid directly to Integrated Health and Behavior. I am financially responsible for non-covered services. I also authorize the physician to release any information required for payment, which may include otherwise protected information.

Signed:_____

Date:_____ If signing on behalf of someone else, what is your relationship: _____