DEMOGRAPHIC INFORMATION

The Clinic for Mental Health & Wellness
502 S 4th Street
Laramie, WY 82070
Phone: (307) 755 – 1000
Fax: (307) 742 – 9717

Personal Information:

DATE:		REFERRAL SOURCE:	
LAST NAME:	FIRST NAME:	MI:	NICKNAME:
SOCIAL SECURITY NO:		D.O.B:	
HOME ADDRESS:		CITY:	STATE:	ZIP:
BILLING ADDRESS:		CITY:	STATE:	ZIP:
GENDER:	RELATIONSHIP STATUS:	PREFERRED LANGUAGE:	RACE ETHNICITY:

Contact Information:

INDICATE BEST CONTACT METHOD:

CELL PHONE #: Message: YES NO Text: YES NO	HOME PHONE #: Message: YES NO	WORK PHONE #: Message: YES NO

Email: May we contact you by email: YES NO

Email for telehealth services (leave blank if same as above):

EMERENCY CONTACT / NEXT OF KIN INFORMATION: May we contact this person in case of an emergency? YES NO

FIRST NAME	LAST NAME	RELATION:	PHONE:

RESPONSIBLE PARTY / GUARDIAN INFORMATION:

FIRST NAME	LAST NAME	RELATION:	PHONE:

Updated 12/20

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Payment Information:

PAYMENT SOURCE (select one):

☐ INSURANCE

☐ SELF PAY

INSURANCE INFORMATION: **PRIMARY** (PLEASE BRING OR COPY CARD)

Insured Name:	Relationship to Patient:	DOB:
Insurance Company:		
Policy No.	Group No.	Employer:

INSURANCE INFORMATION: **SECONDARY** (PLEASE BRING OR COPY CARD)

Insured Name:	Relationship to Patient:	DOB:
Insurance Company:		
Policy No.	Group No.	Employer:

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by The Clinic for Mental Health and Wellness. I assign and authorize payments to the Clinic for Mental Health and Wellness. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

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Client / Responsible Party / Guardian Signature **Date**