THE CLINIC
FOR MENTAL HEALTH & WELLNESS

DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION

Date:		Referral Source:	
LAST NAME:	FIRST NAME:	MI:	NICKNAME:
D.O.B:		SOCIAL SECURITY NO:	
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):			
HOME ADDRESS:	CITY:	STATE:	ZIP:
BILLING ADDRESS:	CITY:	STATE:	ZIP:

BIRTH SEX:	RELATIONSHIP STATUS:	PREFERRED LANGUAGE:	RACE ETHNICITY:

EMERGENCY CONTACT / NEXT OF KIN INFORMATION We would contact this person in case of an emergency

FIRST NAME	LAST NAME	RELATIONSHIP:	PHONE:

RESPONSIBLE PARTY / GUARDIAN INFORMATION

FIRST NAME	LAST NAME	RELATIONSHIP:	PHONE:

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DEMOGRAPHIC INFORMATION

PAYMENT INFORMATION

PAYMENT SOURCE (select one):

- ☐ INSURANCE
- ☐ SELF PAY

INSURANCE INFORMATION: PRIMARY (PLEASE BRING OR COPY CARD)

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

INSURANCE INFORMATION: SECONDARY (PLEASE BRING OR COPY CARD)

Insured Name:	Relationship to Patient:	DOB of policy holder:
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 coinsurance except where my liability is limited by contract or state or federal law.

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