Southern Illinois Institute of Behavioral Health

Client Registration Form

Please complete all pertinent information and print legibly. When completed, sign and date on the back of this form.

CLIENT INFORMATION

Client name: ______________________________ DOB: ______________ Age: ________
Last First MI

Gender: Male Female SSN: ______________________

Marital Status: ______________ Spouse's Name: ______________________

Occupation: Employed Unemployed Disabled FT Student PT Student Other _______________
If employed Professional Title: ______________________

Address: ______________________________

____

Phone Number: Home: ______________ May we leave a message? Yes No
Cell: ______________ May we leave a message? Yes No
Work: ______________ May we leave a message? Yes No

E-Mail Address: ______________________________

Preferred Method of Contact: Home Phone Cell Phone Work Phone E-Mail Other ________________

Family Physician: ______________________ Phone Number: ______________
Psychiatrist: ______________________ Phone Number: ______________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________
Phone Number: ______________________ cell work home other ____________________

IF CLIENT IS A MINOR

Mother's Name: ______________________ DOB: ______________
Address (if different): ______________________________

____

Phone Number: Home: ______________ May we leave a message? Yes No
Cell: ______________ May we leave a message? Yes No
Work: ______________ May we leave a message? Yes No

Father's Name: ______________________ DOB: ______________
Address (if different): ______________________________

____

Phone Number: Home: ______________ May we leave a message? Yes No
Cell: ______________ May we leave a message? Yes No
Work: ______________ May we leave a message? Yes No

Please continue to the back of this form.

FINANCIAL ARRANGEMENTS

If you have insurance, I will help you to receive your maximum benefits. I file claims as a courtesy to my clients. However, insurance is a contract between you and your insurance company and I cannot guarantee benefits.

We require that you pay your deductible and any estimated co-payments before each session. Cash and checks are glady accepted or you may pay online via paypal at www.siiobh.com.

PRIMARY INSURANCE

Insurance Company: ______________________ Phone Number: ______________________

Subscriber Name: ______________________ DOB: ______________________

Subscriber Address: ______________________

Subscriber's Relationship to Client: ______________________

Subscriber ID: ______________________ Group Number: ______________________

Authorization Number: ______________________

SECONDARY INSURANCE

Insurance Company: ______________________ Phone Number: ______________________

Subscriber Name: ______________________ DOB: ______________________

Subscriber Address: ______________________

Subscriber's Relationship to Client: ______________________

Subscriber ID: ______________________ Group Number: ______________________

Authorization Number: ______________________

EAP

If you are using Employee Assistance benefits, please provide us with the following information.

EAP Company: Aetna United Beh. Health Cigna Magellan ComPsych Other ________________

Authorization Number: ______________________ No. of Approved Visits: ______________________

PLEASE READ AND SIGN THE FOLLOWING CONSENT

1. I consent to treatment as necessary and desirable to the named client.
2. I agree that I have or will read the provided HIPPA information and understand my rights as a client.
3. I understand that regardless of insurance coverage, I am responsible for all charges for treatment or services including additional legal and collection fees required as a result of non-payment. I agree to pay for treatment or services in full at the time of service.
4. I understand that if insurance is filed, my insurance company may ask your clinican to provide certain information obtained during my session or treatment (such as diagnosis, treatment plans, or treatment methods). I authorize Southern Illinois Institute of Behavioral Health to release any medical or other information necessary to process claims.
5. I authorize payment of insurance benefits otherwise payable to me, to be paid directly to this provider for the services described on the health insurance claim form, unless other regulations apply.
6. I agree to notify this office immediately of changes in my insurance coverage. If not, I agree to be responsible for fees associated with non-authorized services. I also agree to notify this office of changes in address, employment, etc.

Client Signature: ______________________ Date: ______________________

Parent/Guardian Signature: ______________________ Date: ______________________

Provider Signature: ______________________ Date: ______________________