

Behavior Consultants

Helping the Neurologically-Impaired to Recover

Client Registration and Eligibility Form

Today's Date: ___/___/___

Client Last Name First Name MI Date of Birth M F Sex

Current Street Address City State Zip

Mailing Address (if different from street address) City State Zip

Home Phone Cell Phone Alt. Phone

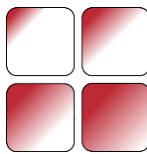
Parent or Guardian Email @ Client SS#

Insurance Information

Primary Insurance	Secondary Insurance
Subscriber Name: _____	Subscriber Name: _____
DOB: ___/___/___	DOB: ___/___/___
SS#: ___-___-___	SS#: ___-___-___
Insurance Company: _____	Insurance Company: _____
Claim Address: _____	Claim Address: _____
ID/Contract #: _____	ID/Contract #: _____
Group #: _____	Group #: _____
Insurance Self-Funded: ___Yes ___No	Insurance Self-Funded: ___Yes ___No
PCP (if listed): _____	PCP (if listed): _____
Please list the telephone numbers specified on your insurance card: _____-_____-_____ _____-_____-_____ _____-_____-_____	Please list the telephone numbers specified on your insurance card: _____-_____-_____ _____-_____-_____ _____-_____-_____
Prescribing MD: _____	Prescribing MD: _____

Legal / Financially Responsible Party

_____/___/___ M ___ F ___



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Last Name _____ First Name _____ MI _____ Date of Birth _____ Sex _____
Today's Date: ___/___/___

Street Address _____ City _____ State _____ Zip _____

Employer Name _____ Address _____

Emergency Contact

Name: _____ Telephone: ___ - ___ - _____ Relationship: _____

Address: _____

Do we have your authorization to contact this person concerning your medical services if the need arises? ___ Yes ___ No

____ Initial (Parent or Responsible Party)

Consent and Release

I hereby consent to treatment by, and authorize insurance benefits be paid directly to Behavior Consultants, Inc. I agree that I am responsible to pay 1) for services not covered by my insurance company, 2) co-payments and deductibles, and 3) any expense associated with the collection of a debt owed to them by me (i.e., Attorney fee, court cost, or collection agency fee). I also consent to the release of pertinent medical information to my insurance carrier(s) for the purpose of processing health care claims.

Print Name

X _____ / /
Signature of Responsible Party Date

X _____ / /
Witness Date