Behavior Consultants

Helping the Neurologically-Impaired to Recover

Client Registration and Eligibility Form

Today's Date: ___/___/___

_____ ____ ___/___/___ M___F___
Client Last Name First Name MI Date of Birth 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

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

Prescribing MD:_____

Secondary Insurance

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

Prescribing MD:_____

Legal / Financially Responsible Party

_____ ____ ___/___/___ M___F___

Committed to Family Preservation
108 North Maple St. # 93 Saline, MI 48176 • (734) 429-7938 • Fax (734) 944-8140
www.behaviorconsultantsinc.com

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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

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