Feller Behavioral Health

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For more information - FellerBehavioralHealth.com

Helping Individuals, Couples and Families Put the Pieces Together

Personal Information

First Name_____Last Name_____Date____/____/____

Street Address_____City_____State_____Zip_____

Home Phone ( )_____Work phone ( )_____Cell phone ( )_____

Email_____ Sex: (M) (F)

Birthdate_____/____/_____ Social Security #_____-____-_____Employer_____

List present health problems or diagnosis:_____

List medication currently taking_____

Referred by_____

Spouse or Parent Information

First Name_____Last Name_____Date____/____/____

Street Address_____City_____State_____Zip_____

Home Phone ( )_____Work phone ( )_____Cell phone ( )_____

Email_____ Sex: (M) (F)

Birthdate_____/____/_____ Social Security #_____-____-_____Employer_____

Insurance Information

Primary Insurance_____Policy #_____

Employer_____Work Phone ( ) _____

Policy Holder Name_____Policy Holder Date of Birth_____/_____/_____

Secondary Insurance_____Policy #_____

Employer_____Work Phone ( ) _____

Policy Holder Name_____Policy Holder Date of Birth_____/_____/_____

Payment/copay is required at the time of service unless previous arrangements have been made. A 'repeat billing charge' will be added to all accounts 60 days old to defray the cost of sending repeat statements. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost incurred in said unpaid balance, including a reasonable attorney fee. If my check is returned unpaid, my signature authorizes that a fee, as allowable by state law be charged to my account in addition to the check's full value.

Authorization: I hereby authorize the release of any medical information necessary to process any insurance claims. Payment of insurance benefits may be made directly to Feller Behavior Health Services (FBHS). I understand that I am responsible to FBHS for charges not covered by this authorization. Copays are due at the time of service.

_____ _____

Signature of patient (OR legal guardian if patient is under 18) Date