

BRIGHTON FAMILY CENTER, PLC

NON-CONFIDENTIAL PATIENT INFORMATION

GENERAL INFORMATION

Date: _____
Patient Name: _____ Gender: _____
Date of Birth: _____ Age: _____ Marital Status (*circle one*): SINGLE MARRIED WIDOWED DIVORCED
FULL Address: _____
street city state zip
Phone: (____) (____) Social Sec#: _____ Driver Lic# _____
home cell
Employer/School: _____
NAME ADDRESS: street city state zip
Employer/School: _____ (____)
Occupation Work Phone and Extension # of Years Employed
E-Mail: _____ Who Referred You: _____
Emergency Contact (name, phone, relationship): _____
With what issues would you like help, and when did they begin: _____

CURRENT MEDICAL CONDITIONS

Condition/Illness	Medications & Dosage	Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Physician: _____ Phone: (____)

May we discuss these issues with these clinicians. (**INITIAL** one): _____ **YES** _____ **NO**
Have you ever been treated by a mental health provider? (*circle one*): **YES** **NO** If yes, name of provider, phone number, treatment dates:

OTHER MEMBERS OF YOUR HOUSEHOLD

Name	Relationship	Age	Name	Relationship	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

INSURANCE INFORMATION: (please also provide copies of **FRONT AND BACK** of insurance cards)

<u>PRIMARY INSURANCE CO.:</u>	<u>SECONDARY INSURANCE CO.:</u>
Address of Ins.: _____	Address of Ins.: _____
Phone: (____)	Phone: (____)
Is Preauthorization needed? _____ Yes _____ No	Is Preauthorization needed? _____ Yes _____ No
Authorization Number: _____	Authorization Number: _____
Circle Patient's Relationship to Insured: Self Spouse Child Other	Circle Patient's Relationship to Insured: Self Spouse Child
Name of Insured: _____	Name of Insured: _____
Insured's Employer _____	Insured's Employer _____
Date of Birth of Insured: _____	Date of Birth of Insured: _____
ID#: _____	ID#: _____
Group#: _____	Group#: _____

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance/managed care company to make payment directly to my provider for services rendered. I authorize my provider to provide information to the payer for purposes of obtaining reimbursement.

SIGNATURE: _____ Date: _____

if different from above: FULL Address: _____

BILLING AND PAYMENTS

Brighton Family Center, PLC. is able to provide the service of billing insurance companies, work EAPs, or other third party payers as a courtesy to our patients. However, **PAYMENT FOR SERVICES RENDERED IS ULTIMATELY YOUR RESPONSIBILITY**. This includes providing accurate and current information to us pertaining to your coverage, as well as obtaining initial authorization for treatment and authorizations for ongoing treatment as required by your third party payer. In the event that your third party payer fails to provide payment within 30 days of submission of charges, as mandated by state law, the monies owed to Brighton Family Center, PLC. are your responsibility.

PERSON LEGALLY RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT:

Name: _____ email: _____

FULL Address: _____
street city state zip

Phone: Home () _____ Cell () _____ Work () _____

I AGREE TO ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES INCURRED.

Signed: _____ **Date:** _____

SCHEDULED APPOINTMENTS:

- Cancellation of appointments, for any reason, **with less than a 24 business hour notice** will result in a charge of \$50.00, which is due from the patient/person legally responsible for payment. Insurance does not normally cover this fee.
- Two cancelled or failed appointments may be grounds for termination of services.

FEES:

PAYMENT (INCLUDING COPAYMENT) IS EXPECTED AT TIME OF SERVICE:

Methods of payment include: CASH, CHECK, or CHARGE CARDS

If charge card is your preferred method of payment, you may provide your information here, which will indicate your agreement to have copays charged to your card after each session.

Circle type of card: **MasterCard** **VISA** **AMEX** **DISCOVER**

Name on card: _____

Card Number: _____

Expiration Date: _____ Security # on back of card: _____

Address Bill Received: _____
street city state zip

- An additional \$25.00 charge will be assessed for checks returned unpaid for any reason.
- Cash, co-pays, and/or deductible monies outstanding for more than 60 days will be charged an interest rate of 12% per annum until paid.
- Additional fees (\$35.00 per 15 minutes) will be charged for the following services: Letters, reports, completion of forms, telephone calls, emails, review of records, or other activities occurring beyond the scheduled session times. These fees are not covered by insurance, are your responsibility, and are payable at the time of service.
- Failure to pay fees in a timely manner may result in your account being turned over to a collection agency, and negative entries may appear on credit reports (e.g. TRW). Should your account need to go to collections, a fee of \$100.00 will be added to the balance owed toward covering collection costs, and for which you are responsible.

Patient Signature: _____ **Date:** _____

Responsible Party Signature: _____ **Date:** _____

