MENTAL HEALTH SOLUTIONS S.C.

REGISTRATION FORM

PERSONAL INFORMATION: Date: _____

Mr. Ms. Mrs. Dr. Other: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ Preferred Pronouns: _____

Birth Date: _____ Age: _____ Gender: M F

Street: _____ Apt: _____ City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____ Home Cell Work

Email Address: _____

AUTOMATED APPOINTMENT REMINDERS
Please check at least ONE option.
We are not responsible for failure to receive messages, please ensure you are keeping another record of your appointments.

_____**CALL** preferred phone number _____**TEXT** preferred phone number _____ **EMAIL** reminder _____ I **DO NOT** want any reminders

EDUCATION: Highest level of education: **Elem Middle High Associates Tech College Masters PhD MD DDS JD DVM Other**

RELATIONSHIP STATUS: Divorced Married Partnered Remarried Separated Single Widowed

BUSINESS: Job Title or Student: _____ Business or School Name: _____

FAMILY INFORMATION:
For minor child give names of parents. If you are married or partnered, give name of significant other.

Name: _____ Sex: M F

Relationship: Mother Father Wife Husband Other _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____

Preferred Phone: (_____) _____

Employer: _____

Name: _____ Sex: M F

Relationship: Mother Father Wife Husband Other _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____

Preferred Phone: (_____) _____

Employer: _____

RESPONSIBLE PARTY: Who should be billed for amounts not covered by insurance?
Clients 18 years and older are the responsible party unless there is a legal guardian on file with Mental Health Solutions
Please Circle One Self Spouse Parent Guardian Agency Other

Name: _____ Birth Date: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: (_____) _____ Alternate Phone: (_____) _____

PLEASE SEE REVERSE TO CONTINUE INSURANCE INFORMATION

MENTAL HEALTH SOLUTIONS S.C.

NEW CLIENT INSURANCE INFORMATION

Please Provide Us With the Current Insurance Card(s)

PRIMARY INSURANCE

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

ID #: _____

Group #: _____

Client Relationship to Policy Holder:

_____

SECONDARY INSURANCE

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

ID #: _____

Group #: _____

Client Relationship to Policy Holder:

_____

DOES YOUR INSURANCE COMPANY REQUIRE PRIOR AUTHORIZATION FOR SERVICES?

YES___ NO___

If Prior Authorization is Required and the Client or Client's Agent Fails to Contact the Insurance Provider to Obtain the Authorization, the Client Accepts Full Financial Responsibility for Any and All Charges.

Please check the boxes below to confirm you have read or been offered the Copayment Policy and the Consumer Rights of Individuals Receiving Treatment. If you would like copies of these documents, please ask the front administrative staff.

☐ Acknowledge of Copayment Policy ☐ Acknowledge of Consumer Rights of Individuals Receiving Treatment

I hereby attest that the above provided information is accurate. I agree to obtain any prior authorization(s) needed by my insurance(s). I authorize insurance(s) to make payments directly to: Mental Health Solutions, S.C.. I also authorize the release of any medical information necessary to process my insurance claims if applicable.

Signature of Client (14 and Older): _____ Date: _____

Printed Name of Authorized Person: _____

Signature of Authorized Person: _____ Date: _____

If signed by a person other than the patient, stated authority to do so (Circle one):

Legal Authority Legal Guardian Next of Kin Parent of Minor Power of Attorney