MRN: _______________ **Date:** _____________ **Time Arrived:** _____________

THIS SECTION IS FOR PATIENT INFORMATION ONLY:

Full Legal Name: ____
Last First M.I. (Sr., Jr., II, etc.)

Have you previously received any other mental health services? □ No □ Yes Name of facility: _______________

Gender: □ Male □ Female □ Transgender Male to Female □ Transgender Female to Male

Social Security #: _________________________ **Date of Birth:** _______________________________

Marital Status: □ Never Married □ Married □ Divorced □ Separated □ Widow(er) □ Common Law

Address: ____ **City:** __________________________________

State: _____ **Zip:** ____________ **Primary Phone:** __________________ **Alt. Phone:** __________________

Referred by: _____________________________ **Highest Level of Education:** ____________________________

Military Status: □ No Service □ Active □ Veteran

Employer: _________________________ **Do you have current insurance?** □ No □ Yes: __________________

Race/Ethnicity (mark all that apply):

□ American Indian/Alaskan Native □ Asian □ Black/African American □ Hispanic/Latino
□ Native Hawaiian/Pacific Islander □ White/Caucasian □ Other/Unknown

Would you like to receive appointment reminders? □ Yes □ No

Presenting Problem: ____

If client is a child, will anyone else be bringing him/her to Four County? (If yes, release of information needed):

____ ____

STOP HERE! Reverse side will be completed by staff.

OFFICE USE ONLY (scan both sides of form) ☐ **EAP**

MRN: ____________ **Client Name:** ______________________________

Emergency Contact	Financially Responsible Party
Primary Emergency Contact: ______________________________ Phone #: ______________ Relationship: ______________ **Secondary** Emergency Contact: ______________________________ Phone #: ______________ Relationship: ______________	Responsible Party for Payment: ______________________ Relationship to Patient: ____________________________ Social Security #: ________________ DOB: ____________ Address: ____ City: __________________ State: _____ Zip: __________ Phone #: _______________ Employer: _______________
Insurance Information	**Secondary Insurance Information**
Cardholder Name: ______________________________ Relationship: ___________ Employer: _______________ Insurance: _____________ Policy #: _________________ Social Security #: _______________ DOB: ____________ Address: _______________________________________ City: _________________ State: ______ Zip: _________ Phone #: _______________________________________	Cardholder Name: _________________________________ Relationship: ___________ Employer: ________________ Insurance: _____________ Policy #: __________________ Social Security #: _______________ DOB: _____________ Address: ____ City: __________________ State: ______ Zip: _________ Phone #: ____

IMPORTANT – READ CAREFULLY

The patient or responsible party signing this form hereby certifies that the information on this form is complete and correct, and authorizes Four County Mental Health Center, Inc. to send information for billing as requested by payment sources. This information may include, if specifically requested, copies of the admission evaluation, treatment plans, discharge summary, clinical progress notes, and any other records produced by this agency. This authorization will expire upon completion of processing of my insurance claim and any subsequent requests or audits by the payment source, unless expressly revoked by me at an earlier date. I further understand that revoking my consent may result in my being responsible for payment of the claim and the above payment source(s) not being used.

If the information furnished above is not accurate or complete, Four County reserves the right to demand and receive its undiscounted fee. If insurance coverage is lost, patient will be responsible for payment. If delinquent, this account may be sent for collection and any unpaid portion may show up on your credit report. Four County reserves the right to charge an additional fee of 10% to recover a portion of the collection costs.

_________________________________ _________ _____________________________ _________

Signature - Financially Responsible Party Date **Staff Member Signature** Date

____

Printed Name - Financially Responsible Party