CEDAR CENTRE PSYCHIATRIC GROUP L.L.P.

PLEASE PRINT LEGIBLY!! PLEASE FILL OUT, SIGN AND DATE BOTH SIDES OF THE FORM!

Patient's Full Name_____

Address_____

City, State & Zip_____

Home Phone_____ Social Security #_____

Date of Birth_____ Male ☐ Female ☐ Student full time ☐ part time ☐

Guarantor's Full Name_____

Address_____

City, State & Zip_____

Home Phone_____ Social Security #_____

Date of Birth_____ Male ☐ Female ☐ Work Phone_____

Employer_____ Marital Status_____

Emergency Contact:

Name_____Phone_____Relationship_____

INSURANCE INFORMATION

Insurance Company Name_____

Claims Address_____

City, State & Zip_____

Insurance Phone # _____Precertification Required? Yes ☐ No ☐

Name of Subscriber on Card_____

Date of Birth_____Employer_____

Policy #_____Group #_____

Secondary Insurance Company Name_____

Claims Address_____

City, State & Zip_____

Insurance Phone #_____Precertification Required? Yes ☐ No ☐

Name of Subscriber on Card_____

Date of Birth_____Employer_____

Policy #_____Group #_____

I authorize payment of medical benefits to Cedar Centre Psychiatric Group. I understand Cedar Centre will file my insurance as a courtesy to me, but I am financially responsible and agree to pay Cedar Centre within 60 days, even if my insurance has not yet paid.

Name_____ **Date**_____

OVER

NOTICE TO ENROLLEES OF ANY HMO PLAN:

If your benefit plan requires you to contact your Mental Health Plan, prior to receiving services at our office and you have not done so, you will be responsible for payment in full of services received.

Please initial here: _____

CONSENT TO RELEASE MENTAL HEALTH INFORMATION

I, the undersigned, hereby authorize Cedar Centre Psychiatric Group to disclose to:

_____ _____

Name of Insurance Company **Address**

The following information:
A) Administrative Data (i.e., name, address, age)
B) Diagnosis
C) Voluntary or involuntary treatment status
D) Estimated time during which treatment might continue
E) Treatment information including prescriptions & current status

I understand that the information is to be used for billing purposes; I further understand that this will be a lifetime agreement, which I may revoke at any time buy sending written notice to Cedar Centre Psychiatric Group.

I understand that any release, which has been made prior to my revocation and which was made in reliance upon this authorization, shall not constitute a breach of my rights to confidentiality. I understand that I may request to review the disclosed information by contacting Cedar Centre Psychiatric Group.

A photocopy of this consent shall be deemed the same as the original.

_____ _____

Name **Date**